

ASSEMBLY BILL

No. 2

Introduced by Assembly Member Pan

January 29, 2013

An act to amend Sections 1357.51, 1357.503, 1357.504, 1357.509, 1357.512, 1363, and 1399.829 of, to amend the heading of Article 11.7 (commencing with Section 1399.825) of Chapter 2.2 of Division 2 of, to amend and add Sections 1389.4 and 1389.7 of, to amend and repeal Section 1389.5 of, to amend, repeal, and add Sections 1399.805 and 1399.811 of, to add Sections 1348.96 and 1399.836 to, to add Article 11.8 (commencing with Section 1399.845) to Chapter 2.2 of Division 2 of, and to repeal Sections 1357.510 and 1399.816 of, the Health and Safety Code, and to amend Sections 10198.7, 10753.05, 10753.06.5, 10753.11, 10753.12, 10753.14, and 10954 of, to amend the heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of, to amend and add Sections 10113.95 and 10119.2 of, to amend and repeal Section 10119.1 of, to amend, repeal, and add Sections 10901.3 and 10901.9 of, to add Sections 10127.21 and 10960.5 to, to add Chapter 9.9 (commencing with Section 10965) to Part 2 of Division 2 of, to add Part 6.25 (commencing with Section 12694.50) to Division 2 of, and to repeal Section 10902.4 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2, as introduced, Pan. Health care coverage.

(1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in

the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual. PPACA prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to that plan or coverage. PPACA allows the premium rate charged by a health insurance issuer offering small group or individual coverage to vary only by rating area, age, tobacco use, and whether the coverage is for an individual or family and prohibits discrimination against individuals based on health status, as specified. PPACA requires an issuer to consider all enrollees in its individual market plans to be part of a single risk pool and to consider all enrollees in its small group market plans to be part of a single risk pool, as specified. PPACA also requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires plans and insurers offering coverage in the individual market to offer coverage for a child subject to specified requirements. Existing law establishes the California Health Benefit Exchange (Exchange) to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014.

This bill would require a plan or insurer, on and after October 1, 2013, to offer, market, and sell all of the plan's or insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan or insurer provides or arranges for the provision of health care services, as specified, but would require plans and insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. The bill would prohibit these health benefit plans from imposing any preexisting condition upon any individual and from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified. The bill would require a health care service plan or health insurer to

consider the claims experience of all enrollees or insureds of its nongrandfathered individual health benefit plans to be part of a single risk pool, would require the plan or insurer to establish a specified index rate for that market, and would authorize the plan or insurer to vary premiums from the index rate based only on specified factors. The bill would authorize plans and insurers to use only age, geographic region, and family size for purposes of establishing rates for individual health benefit plans, as specified. The bill would require plans and insurers to provide specified information regarding the Exchange to applicants for and subscribers of individual health benefit plans offered outside the Exchange. The bill would prohibit a plan or insurer from advertising or marketing an individual grandfathered health plan for the purpose of enrolling a dependent of the subscriber or policyholder in the plan and would also require plans and insurers to annually issue a specified notice to subscribers and policyholders enrolled in a grandfathered plan.

Existing law requires plans and insurers to guarantee issue their small employer health benefit plans, as specified. With respect to nongrandfathered small employer health benefit plans for plan years on or after January 1, 2014, among other things, existing law provides certain exceptions from the guarantee issue requirement, allows the premium for small employer health benefit plans to vary only by age, geographic region, and family size, as specified, and requires plans and insurers to provide special enrollment periods and coverage effective dates consistent with the individual nongrandfathered market in the state. Existing law provides that these provisions shall be inoperative if specified provisions of PPACA are repealed.

This bill would modify the small employer special enrollment periods and coverage effective dates for purposes of consistency with the individual market reforms described above. The bill would also modify the exceptions from the guarantee issue requirement and the manner in which a plan or insurer determines premium rates for a small employer health benefit plan, as specified. The bill would also require a plan or insurer to consider the claims experience of all enrollees of its nongrandfathered small employer health benefit plans to be part of a single risk pool, would require the plan or insurer to establish a specified index rate for that market, and would authorize the plan or insurer to vary premiums from the index rate based only on specified factors. The bill would delete the provisions making these provisions inoperative if specified provisions of PPACA are repealed.

Because a willful violation of these requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

(2) PPACA requires a state or the United States Secretary of Health and Human Services to implement a risk adjustment program for the 2014 benefit year and every benefit year thereafter, under which a charge is assessed on low actuarial risk plans and a payment is made to high actuarial risk plans, as specified. If a state that elects to operate an American Health Benefit Exchange elects not to administer this risk adjustment program, the secretary will operate the program and issuers will be required to submit data for purposes of the program to the secretary.

This bill would require that any data submitted by health care service plans and health insurers to the secretary for purposes of the risk adjustment program also be submitted to the Department of Managed Health Care or the Department of Insurance.

(3) PPACA requires health insurance issuers to provide a summary of benefits and coverage explanation pursuant to specified standards to applicants and enrollees or policyholders.

Existing law requires health care service plans to use disclosure forms that contain specified information regarding the contracts issued by the plan, including the benefits and coverage of the contract, and the exceptions, reductions, and limitations that apply to the contract. Existing law requires health care service plans that offer individual or small group coverage to also provide a uniform health plan benefits and coverage matrix containing the plan's major provisions, as specified.

This bill would authorize the Department of Managed Health Care to waive or modify those requirements for purposes of compliance with PPACA through issuance of all-plan letters until January 1, 2015.

(4) Existing law requires a health care service plan or a health insurer offering individual plan contracts or individual insurance policies to fairly and affirmatively offer, market, and sell certain individual contracts and policies to all federally eligible defined individuals, as defined, in each service area in which the plan or insurer provides or arranges for the provision of health care services. Existing law prohibits the premium for those policies and contracts from exceeding the premium paid by a subscriber of the California Major Risk Medical Insurance Program who is of the same age and resides in the same geographic region as the federally eligible defined individual, as specified.

This bill would instead prohibit the premium for those policies and contracts from exceeding the premium for a specified plan offered in the individual market through the California Health Benefit Exchange in the rating area in which the individual resides. The bill would make this requirement operative on the later of January 1, 2014, or the 91st day following the adjournment of the 2013–14 First Extraordinary Session. Because a willful violation of this requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

(5) Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health care services to eligible children through participating health, dental, and vision care plans, as defined. To be eligible for the program, existing law requires applicants to, among other requirements, be less than 19 years of age and have a limited gross household income, as specified. Existing law provides for the transition of specified enrollees of the Healthy Families Program to the Medi-Cal program, to the extent that those individuals are otherwise eligible, no sooner than January 1, 2013.

This bill would require plans offering coverage to Healthy Families Program enrollees, on or after January 1, 2012, including those transitioned to the Medi-Cal program, to offer 18 months of coverage, until a specified date, to individuals who were or are disenrolled from the program due to ineligibility because of age and are not eligible for full scope coverage under Medi-Cal. The bill would require plans to provide notice of eligibility for this coverage within a specified period of time and would require beneficiaries electing this coverage to pay no more than 110% of the average per subscriber payment made to all participating health, dental, or vision plans for program coverage, as specified.

(6) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1348.96 is added to the Health and Safety
2 Code, to read:

3 1348.96. Any data submitted by a health care service plan to
4 the United States Secretary of Health and Human Services, or his
5 or her designee, for purposes of the risk adjustment program
6 described in Section 1343 of the federal Patient Protection and
7 Affordable Care Act (42 U.S.C. Sec. 18063) shall be concurrently
8 submitted to the department.

9 SEC. 2. Section 1357.51 of the Health and Safety Code, as
10 added by Chapter 852 of the Statutes of 2012, is amended to read:

11 ~~1357.51. (a) A nongrandfathered health benefit plan for group~~
12 ~~or individual coverage or a grandfathered health benefit plan for~~
13 group coverage shall not impose any preexisting condition
14 *provision* or waived condition *provision* upon any enrollee.

15 (b) *A nongrandfathered health benefit plan for individual*
16 *coverage shall not impose any preexisting condition provision or*
17 *waivered condition provision upon any enrollee.* A grandfathered
18 health benefit plan for individual coverage shall not exclude
19 coverage on the basis of a waived condition provision or
20 preexisting condition provision for a period greater than 12 months
21 following the enrollee's effective date of coverage, nor limit or
22 exclude coverage for a specific enrollee by type of illness,
23 treatment, medical condition, or accident, except for satisfaction
24 of a preexisting condition ~~clause~~ *provision* or waived condition
25 provision pursuant to this article. Waivered condition provisions
26 or preexisting condition provisions contained in individual
27 grandfathered health benefit plans may relate only to conditions
28 for which medical advice, diagnosis, care, or treatment, including
29 use of prescription drugs, was recommended or received from a
30 licensed health practitioner during the 12 months immediately
31 preceding the effective date of coverage.

32 (c) (1) A health benefit plan for group coverage may apply a
33 waiting period of up to 60 days as a condition of employment if
34 applied equally to all eligible employees and dependents and if
35 consistent with PPACA. A health benefit plan for group coverage
36 through a health maintenance organization, as defined in Section
37 2791 of the federal Public Health Service Act, shall not impose
38 any affiliation period that exceeds 60 days. A waiting or affiliation

1 period shall not be based on a preexisting condition of an employee
2 or dependent, the health status of an employee or dependent, or
3 any other factor listed in Section 1357.52. An affiliation period
4 shall run concurrently with a waiting period. During the waiting
5 or affiliation period, the plan is not required to provide health care
6 services and no premium shall be charged to the subscriber or
7 enrollees.

8 (2) A health benefit plan for individual coverage shall not
9 impose any waiting or affiliation period.

10 (d) In determining whether a preexisting condition provision,
11 a waived condition provision, or a waiting or affiliation period
12 applies to an enrollee, a plan shall credit the time the enrollee was
13 covered under creditable coverage, provided that the enrollee
14 becomes eligible for coverage under the succeeding plan contract
15 within 62 days of termination of prior coverage, exclusive of any
16 waiting or affiliation period, and applies for coverage under the
17 succeeding plan within the applicable enrollment period. A plan
18 shall also credit any time that an eligible employee must wait
19 before enrolling in the plan, including any postenrollment or
20 employer-imposed waiting or affiliation period.

21 However, if a person's employment has ended, the availability
22 of health coverage offered through employment or sponsored by
23 an employer has terminated, or an employer's contribution toward
24 health coverage has terminated, a plan shall credit the time the
25 person was covered under creditable coverage if the person
26 becomes eligible for health coverage offered through employment
27 or sponsored by an employer within 180 days, exclusive of any
28 waiting or affiliation period, and applies for coverage under the
29 succeeding plan contract within the applicable enrollment period.

30 (e) An individual's period of creditable coverage shall be
31 certified pursuant to Section 2704(e) of Title XXVII of the federal
32 Public Health Service Act (42 U.S.C. Sec. 300gg-3(e)).

33 SEC. 3. Section 1357.503 of the Health and Safety Code is
34 amended to read:

35 1357.503. (a) (1) On and after October 1, 2013, a plan shall
36 fairly and affirmatively offer, market, and sell all of the plan's
37 small employer health care service plan contracts for plan years
38 on or after January 1, 2014, to all small employers in each service
39 area in which the plan provides or arranges for the provision of
40 health care services.

1 (2) On and after October 1, 2013, a plan shall make available
2 to each small employer all small employer health care service plan
3 contracts that the plan offers and sells to small employers or to
4 associations that include small employers in this state for plan
5 years on or after January 1, 2014.

6 (3) A plan that offers qualified health plans through the
7 Exchange shall be deemed to be in compliance with paragraphs
8 (1) and (2) with respect to small employer health care service plan
9 contracts offered through the Exchange in those geographic regions
10 in which the plan offers plan contracts through the Exchange.

11 (b) A plan shall provide enrollment periods consistent with
12 PPACA and ~~set forth~~ *described* in Section 155.725 of Title 45 of
13 the Code of Federal Regulations. ~~A Commencing January 1, 2014,~~
14 *a plan shall provide special enrollment periods consistent with the*
15 *special enrollment periods* ~~—required in the individual~~
16 ~~nongrandfathered market in the state under~~ *described in* Section
17 1399.849, except for the triggering events identified in paragraphs
18 (d)(3) and (d)(6) of Section 155.420 of Title 45 of the Code of
19 Federal Regulations with respect to plan contracts offered through
20 the Exchange.

21 (c) No plan or solicitor shall induce or otherwise encourage a
22 small employer to separate or otherwise exclude an eligible
23 employee from a health care service plan contract that is provided
24 in connection with employee's employment or membership in a
25 guaranteed association.

26 (d) Every plan shall file with the director the reasonable
27 employee participation requirements and employer contribution
28 requirements that will be applied in offering its plan contracts.
29 Participation requirements shall be applied uniformly among all
30 small employer groups, except that a plan may vary application
31 of minimum employee participation requirements by the size of
32 the small employer group and whether the employer contributes
33 100 percent of the eligible employee's premium. Employer
34 contribution requirements shall not vary by employer size. A health
35 care service plan shall not establish a participation requirement
36 that (1) requires a person who meets the definition of a dependent
37 in Section 1357.500 to enroll as a dependent if he or she is
38 otherwise eligible for coverage and wishes to enroll as an eligible
39 employee and (2) allows a plan to reject an otherwise eligible small
40 employer because of the number of persons that waive coverage

1 due to coverage through another employer. Members of an
2 association eligible for health coverage under subdivision (m) of
3 Section 1357.500, but not electing any health coverage through
4 the association, shall not be counted as eligible employees for
5 purposes of determining whether the guaranteed association meets
6 a plan's reasonable participation standards.

7 (e) The plan shall not reject an application from a small
8 employer for a small employer health care service plan contract
9 if all of the following conditions are met:

10 (1) The small employer offers health benefits to 100 percent of
11 its eligible employees. Employees who waive coverage on the
12 grounds that they have other group coverage shall not be counted
13 as eligible employees.

14 (2) The small employer agrees to make the required premium
15 payments.

16 (3) The small employer agrees to inform the small employer's
17 employees of the availability of coverage and the provision that
18 those not electing coverage must wait until the next open
19 enrollment or a special enrollment period to obtain coverage
20 through the group if they later decide they would like to have
21 coverage.

22 (4) The employees and their dependents who are to be covered
23 by the plan contract work or reside in the service area in which
24 the plan provides or otherwise arranges for the provision of health
25 care services.

26 (f) No plan or solicitor shall, directly or indirectly, engage in
27 the following activities:

28 (1) Encourage or direct small employers to refrain from filing
29 an application for coverage with a plan because of the health status,
30 claims experience, industry, occupation of the small employer, or
31 geographic location provided that it is within the plan's approved
32 service area.

33 (2) Encourage or direct small employers to seek coverage from
34 another plan because of the health status, claims experience,
35 industry, occupation of the small employer, or geographic location
36 provided that it is within the plan's approved service area.

37 (3) *Employ marketing practices or benefit designs that will have*
38 *the effect of discouraging the enrollment of individuals with*
39 *significant health needs.*

1 (g) A plan shall not, directly or indirectly, enter into any
2 contract, agreement, or arrangement with a solicitor that provides
3 for or results in the compensation paid to a solicitor for the sale of
4 a health care service plan contract to be varied because of the health
5 status, claims experience, industry, occupation, or geographic
6 location of the small employer. This subdivision does not apply
7 to a compensation arrangement that provides compensation to a
8 solicitor on the basis of percentage of premium, provided that the
9 percentage shall not vary because of the health status, claims
10 experience, industry, occupation, or geographic area of the small
11 employer.

12 (h) (1) A policy or contract that covers a small employer, as
13 defined in Section 1304(b) of PPACA and in Section 1357.500,
14 shall not establish rules for eligibility, including continued
15 eligibility, of an individual, or dependent of an individual, to enroll
16 under the terms of the policy or contract based on any of the
17 following health status-related factors:

18 (A) Health status.

19 (B) Medical condition, including physical and mental illnesses.

20 (C) Claims experience.

21 (D) Receipt of health care.

22 (E) Medical history.

23 (F) Genetic information.

24 (G) Evidence of insurability, including conditions arising out
25 of acts of domestic violence.

26 (H) Disability.

27 (I) Any other health status-related factor as determined by any
28 federal regulations, rules, or guidance issued pursuant to Section
29 2705 of the federal Public Health Service Act.

30 (2) Notwithstanding Section 1389.1, a health care service plan
31 shall not require an eligible employee or dependent to fill out a
32 health assessment or medical questionnaire prior to enrollment
33 under a small employer health care service plan contract. A health
34 care service plan shall not acquire or request information that
35 relates to a health status-related factor from the applicant or his or
36 her dependent or any other source prior to enrollment of the
37 individual.

38 (i) (1) *A health care service plan shall consider the claims*
39 *experience of all enrollees in all nongrandfathered small employer*
40 *health care service plan contracts offered in the state that are*

1 *subject to subdivision (a), including those enrollees who do not*
2 *enroll in the contracts through the Exchange, to be members of a*
3 *single risk pool.*

4 *(2) Each plan year, a health care service plan shall establish*
5 *an index rate for the small employer market in the state based on*
6 *the total combined claims costs for providing essential health*
7 *benefits, as defined pursuant to Section 1302 of PPACA, within*
8 *the single risk pool required under paragraph (1). The index rate*
9 *shall be adjusted on a market-wide basis based on the total*
10 *expected market-wide payments and charges under the risk*
11 *adjustment and reinsurance programs established for the state*
12 *pursuant to Sections 1343 and 1341 of PPACA. The premium rate*
13 *for all of the health care service plan's nongrandfathered small*
14 *employer health care service plan contracts shall use the*
15 *applicable index rate, as adjusted for total expected market-wide*
16 *payments and charges under the risk adjustment and reinsurance*
17 *programs established for the state pursuant to Sections 1343 and*
18 *1341 of PPACA, subject only to the adjustments permitted under*
19 *paragraph (3).*

20 *(3) A health care service plan may vary premiums rates for a*
21 *particular nongrandfathered small employer health care service*
22 *plan contract from its index rate based only on the following*
23 *actuarially justified plan-specific factors:*

24 *(A) The actuarial value and cost-sharing design of the plan*
25 *contract.*

26 *(B) The plan contract's provider network, delivery system*
27 *characteristics, and utilization management practices.*

28 *(C) The benefits provided under the plan contract that are in*
29 *addition to the essential health benefits, as defined pursuant to*
30 *Section 1302 of PPACA. These additional benefits shall be pooled*
31 *with similar benefits within the single risk pool required under*
32 *paragraph (1) and the claims experience from those benefits shall*
33 *be utilized to determine rate variations for plan contracts that*
34 *offer those benefits in addition to essential health benefits.*

35 *(D) With respect to catastrophic plans, as described in*
36 *subsection (e) of Section 1302 of PPACA, the expected impact of*
37 *the specific eligibility categories for those plans.*

38 *(i)*

39 *(j) A plan shall comply with the requirements of Section 1374.3.*

1 ~~(j) (1) Except as provided in paragraph (2), this section shall~~
2 ~~become inoperative if Section 2702 of the federal Public Health~~
3 ~~Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201~~
4 ~~of PPACA, is repealed, in which case health care services plans~~
5 ~~subject to this section shall instead be governed by Section 1357.03~~
6 ~~to the extent permitted by federal law, and all references in this~~
7 ~~article to this section shall instead refer to Section 1357.03 except~~
8 ~~for purposes of paragraph (2):~~

9 ~~(2) Subdivision (b) of this section shall remain operative with~~
10 ~~respect to health care service plan contracts offered through the~~
11 ~~Exchange:~~

12 SEC. 4. Section 1357.504 of the Health and Safety Code is
13 amended to read:

14 1357.504. (a) With respect to small employer health care
15 service plan contracts offered outside the Exchange, after a small
16 employer submits a completed application form for a plan contract,
17 the health care service plan shall, within 30 days, notify the
18 employer of the employer's actual premium charges for that plan
19 contract established in accordance with Section 1357.512. The
20 employer shall have 30 days in which to exercise the right to buy
21 coverage at the quoted premium charges.

22 (b) ~~(1)~~ Except as provided in ~~paragraph (2)~~ *subdivision (c)*,
23 when a small employer submits a premium payment, based on the
24 quoted premium charges, and that payment is delivered or
25 postmarked, whichever occurs earlier, within the first 15 days of
26 the month, coverage under the plan contract shall become effective
27 no later than the first day of the following month. When that
28 payment is neither delivered nor postmarked until after the 15th
29 day of a month, coverage shall become effective no later than the
30 first day of the second month following delivery or postmark of
31 the payment.

32 ~~(2) A health care service plan shall apply coverage effective~~
33 ~~dates for plan contracts subject to this article consistent with the~~
34 ~~coverage effective dates applicable to nongrandfathered individual~~
35 ~~health care service plan contracts pursuant to Section 1399.849.~~

36 *(c) (1) With respect to a small employer health care service*
37 *plan contract offered through the Exchange, a plan shall apply*
38 *coverage effective dates consistent with those required under*
39 *Section 155.720 of Title 45 of the Code of Federal Regulations*
40 *and paragraph (2) of subdivision (e) of Section 1399.849.*

1 (2) *With respect to a small employer health care service plan*
2 *contract offered outside the Exchange for which an individual*
3 *applies during a special enrollment period described in subdivision*
4 *(b) of Section 1357.503, the following provisions shall apply:*

5 (A) *Coverage under the plan contract shall become effective no*
6 *later than the first day of the first calendar month beginning after*
7 *the date the plan receives the request for special enrollment.*

8 (B) *Notwithstanding subparagraph (A), in the case of a birth,*
9 *adoption, or placement for adoption, coverage under the plan*
10 *contract shall become effective on the date of birth, adoption, or*
11 *placement for adoption.*

12 (e)

13 (d) *During the first 30 days after the effective date of the plan*
14 *contract, the small employer shall have the option of changing*
15 *coverage to a different plan contract offered by the same health*
16 *care service plan. If a small employer notifies the plan of the*
17 *change within the first 15 days of a month, coverage under the*
18 *new plan contract shall become effective no later than the first day*
19 *of the following month. If a small employer notifies the plan of*
20 *the change after the 15th day of a month, coverage under the new*
21 *plan contract shall become effective no later than the first day of*
22 *the second month following notification.*

23 SEC. 5. Section 1357.509 of the Health and Safety Code is
24 amended to read:

25 1357.509. (a) *To the extent permitted by PPACA, no plan*
26 *shall be required to offer a health care service plan contract or*
27 *accept applications for the contract pursuant to this article in the*
28 *case of any of the following:*

29 (a)

30 (1) ~~*To a small employer, if the small employer is not physically*~~
31 ~~*located in a plan's approved service areas, or if an*~~ *the eligible*
32 ~~*employee employees*~~ *and dependents who are to be covered by the*
33 *plan contract do not live, work or reside within a plan's approved*
34 *service areas.*

35 (b) (1) —

36 (2) (A) *Within a specific service area or portion of a service*
37 *area, if a plan reasonably anticipates and demonstrates to the*
38 *satisfaction of the director that it both of the following:*

39 (i) *It will not have sufficient health care delivery resources to*
40 *ensure that health care services will be available and accessible to*

1 the eligible employee and dependents of the employee because of
2 its obligations to existing enrollees.

3 *(ii) It is applying this subparagraph uniformly to all employers*
4 *without regard to the claims experience of those employers, and*
5 *their employees and dependents, or any health status-related factor*
6 *relating to those employees and dependents.*

7 ~~(2)~~

8 (B) A plan that cannot offer a health care service plan contract
9 to small employers because it is lacking in sufficient health care
10 delivery resources within a service area or a portion of a service
11 area pursuant to subparagraph (A) may not offer a contract in the
12 area in which the plan is not offering coverage to small employers
13 to new employer groups with more than 50 eligible employees
14 until the later of the following dates:

15 *(i) The 181st day after the date that coverage is denied pursuant*
16 *to this paragraph.*

17 *(ii) The date the plan notifies the director that it has the ability*
18 *to deliver services to small employer groups, and certifies to the*
19 *director that from the date of the notice it will enroll all small*
20 *employer groups requesting coverage in that area from the plan*
21 ~~*unless the plan has met the requirements of subdivision (d).*~~

22 (C) Subparagraph (B) shall not limit the plan's ability to renew
23 coverage already in force or relieve the plan of the responsibility
24 to renew that coverage as described in Section 1365.

25 (D) Coverage offered within a service area after the period
26 specified in subparagraph (B) shall be subject to the requirements
27 of this section.

28 (b) (1) A health care service plan may decline to offer a health
29 care service plan contract to a small employer if the plan
30 demonstrates to the satisfaction of the director both of the
31 following:

32 (A) It does not have the financial reserves necessary to
33 underwrite additional coverage. In determining whether this
34 subparagraph has been satisfied, the director shall consider, but
35 not be limited to, the plan's compliance with the requirements of
36 Section 1367, Article 6 (commencing with Section 1375), and the
37 rules adopted thereunder.

38 (B) It is applying this paragraph uniformly to all employers
39 without regard to the claims experience of those employers and

1 *their employees and dependents or any health status-related factor*
2 *relating to those employees and dependents.*

3 (2) *A plan that denies coverage to a small employer under*
4 *paragraph (1) shall not offer coverage in the group market before*
5 *the later of the following dates:*

6 (A) *The 181st day after the date that coverage is denied pursuant*
7 *to paragraph (1).*

8 (B) *The date the plan demonstrates to the satisfaction of the*
9 *director that the plan has sufficient financial reserves necessary*
10 *to underwrite additional coverage.*

11 (3) *Paragraph (2) shall not limit the plan's ability to renew*
12 *coverage already in force or relieve the plan of the responsibility*
13 *to renew that coverage as described in Section 1365.*

14 (4) *Coverage offered within a service area after the period*
15 *specified in paragraph (2) shall be subject to the requirements of*
16 *this section.*

17 ~~(3)~~

18 (c) *Nothing in this article shall be construed to limit the*
19 *director's authority to develop and implement a plan of*
20 *rehabilitation for a health care service plan whose financial viability*
21 *or organizational and administrative capacity has become impaired*
22 *to the extent permitted by PPACA.*

23 ~~(e) Offer coverage to a small employer or an eligible employee~~
24 ~~as defined in paragraph (2) of subdivision (e) of Section 1357.500~~
25 ~~that, within 12 months of application for coverage, disenrolled~~
26 ~~from a plan contract offered by the plan.~~

27 ~~(d) (1) The director approves the plan's certification that the~~
28 ~~number of eligible employees and dependents enrolled under~~
29 ~~contracts issued during the current calendar year equals or exceeds~~
30 ~~either of the following:~~

31 ~~(A) In the case of a plan that administers any self-funded health~~
32 ~~coverage arrangements in California, 10 percent of the total~~
33 ~~enrollment of the plan in California as of December 31 of the~~
34 ~~preceding year.~~

35 ~~(B) In the case of a plan that does not administer any self-funded~~
36 ~~health coverage arrangements in California, 8 percent of the total~~
37 ~~enrollment of the plan in California as of December 31 of the~~
38 ~~preceding year. If that certification is approved, the plan shall not~~
39 ~~offer any health care service plan contract to any small employers~~
40 ~~during the remainder of the current year.~~

1 ~~(2) If a health care service plan treats an affiliate or subsidiary~~
2 ~~as a separate carrier for the purpose of this article because one~~
3 ~~health care service plan is qualified under the federal Health~~
4 ~~Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and~~
5 ~~does not offer coverage to small employers, while the affiliate or~~
6 ~~subsidiary offers a plan contract that is not qualified under the~~
7 ~~federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e~~
8 ~~et seq.) and offers plan contracts to small employers, the health~~
9 ~~care service plan offering coverage to small employers shall enroll~~
10 ~~new eligible employees and dependents, equal to the applicable~~
11 ~~percentage of the total enrollment of both the health care service~~
12 ~~plan qualified under the federal Health Maintenance Organization~~
13 ~~Act (42 U.S.C. Sec. 300e et seq.) and its affiliate or subsidiary.~~

14 ~~(3) (A) The certified statement filed pursuant to this subdivision~~
15 ~~shall state the following:~~

16 ~~(i) Whether the plan administers any self-funded health coverage~~
17 ~~arrangements in California.~~

18 ~~(ii) The plan's total enrollment as of December 31 of the~~
19 ~~preceding year.~~

20 ~~(iii) The number of eligible employees and dependents enrolled~~
21 ~~under contracts issued to small employer groups during the current~~
22 ~~calendar year.~~

23 ~~(B) The director shall, within 45 days, approve or disapprove~~
24 ~~the certified statement. If the certified statement is disapproved,~~
25 ~~the plan shall continue to issue coverage as required by Section~~
26 ~~1357.503 and be subject to disciplinary action as set forth in Article~~
27 ~~7 (commencing with Section 1386).~~

28 ~~(e) A health care service plan that, as of December 31 of the~~
29 ~~prior year, had a total enrollment of fewer than 100,000 and 50~~
30 ~~percent or more of the plan's total enrollment have premiums paid~~
31 ~~by the Medi-Cal program.~~

32 ~~(f) A social health maintenance organization, as described in~~
33 ~~subsection (a) of Section 2355 of the federal Deficit Reduction~~
34 ~~Act of 1984 (Public Law 98-369), that, as of December 31 of the~~
35 ~~prior year, had a total enrollment of fewer than 100,000 and has~~
36 ~~50 percent or more of the organization's total enrollment premiums~~
37 ~~paid by the Medi-Cal program or Medicare Program, or by a~~
38 ~~combination of Medi-Cal and Medicare. In no event shall this~~
39 ~~exemption be based upon enrollment in Medicare supplement~~

1 contracts, as described in Article 3.5 (commencing with Section
2 1358).

3 SEC. 6. Section 1357.510 of the Health and Safety Code is
4 repealed.

5 ~~1357.510. The director may require a plan to discontinue the~~
6 ~~offering of contracts or acceptance of applications from any small~~
7 ~~employer or group upon a determination by the director that the~~
8 ~~plan does not have sufficient financial viability, or organizational~~
9 ~~and administrative capacity to ensure the delivery of health care~~
10 ~~services to its enrollees. In determining whether the conditions of~~
11 ~~this section have been met, the director shall consider, but not be~~
12 ~~limited to, the plan's compliance with the requirements of Section~~
13 ~~1367, Article 6 (commencing with Section 1375), and the rules~~
14 ~~adopted thereunder.~~

15 SEC. 7. Section 1357.512 of the Health and Safety Code is
16 amended to read:

17 1357.512. (a) The premium rate for a small employer health
18 care service plan contract shall vary with respect to the particular
19 coverage involved only by the following:

20 (1) Age, pursuant to the age bands established by the United
21 States Secretary of Health and Human Services *and the age rating*
22 *curve established by the Centers for Medicare and Medicaid*
23 *Services* pursuant to Section 2701(a)(3) of the federal Public Health
24 Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall
25 be determined ~~based on the individual's birthday~~ *using the*
26 *individual's age as of the date of the contract issuance or renewal,*
27 *as applicable,* and shall not vary by more than three to one for
28 ~~adults like individuals of different age who are 21 years of age or~~
29 ~~older as described in federal regulations adopted pursuant to~~
30 ~~Section 2701(a)(3) of the federal Public Health Service Act (42~~
31 ~~U.S.C. Sec. 300gg(a)(3)).~~

32 (2) (A) Geographic region. ~~The~~ *Except as provided in*
33 *subparagraph (B),* the geographic regions for purposes of rating
34 shall be the following:

35 (i) Region 1 shall consist of the Counties of Alpine, *Amador,*
36 *Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt,*
37 *Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey,*
38 *Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou,*
39 ~~Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas,~~
40 *Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Tehama,*

- 1 *Trinity, Tulare, Tuolumne, Yolo, and Yuba, Colusa, Amador,*
- 2 *Calaveras, and Tuolumne.*
- 3 (ii) Region 2 shall consist of the Counties of *Fresno, Imperial,*
- 4 *Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin,*
- 5 *San Luis Obispo, Santa Cruz, Solano, Sonoma, Solano, and Marin*
- 6 *and Stanislaus.*
- 7 (iii) ~~Region 3 shall consist of the Counties of Sacramento,~~
- 8 ~~Placer, El Dorado, and Yolo.~~
- 9 (iv)
- 10 (iii) ~~Region 4 3 shall consist of the County Counties of Alameda,~~
- 11 ~~Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.~~
- 12 (v) ~~Region 5 shall consist of the County of Contra Costa.~~
- 13 (vi) ~~Region 6 shall consist of the County of Alameda.~~
- 14 (vii) ~~Region 7 shall consist of the County of Santa Clara.~~
- 15 (viii) ~~Region 8 shall consist of the County of San Mateo.~~
- 16 (ix) ~~Region 9 shall consist of the Counties of Santa Cruz,~~
- 17 ~~Monterey, and San Benito.~~
- 18 (x) ~~Region 10 shall consist of the Counties of San Joaquin,~~
- 19 ~~Stanislaus, Merced, Mariposa, and Tulare.~~
- 20 (xi) ~~Region 11 shall consist of the Counties of Madera, Fresno,~~
- 21 ~~and Kings.~~
- 22 (xii)
- 23 (iv) ~~Region 12 4 shall consist of the Counties of San Luis~~
- 24 ~~Obispo, Orange, Santa Barbara, and Ventura.~~
- 25 (xiii) ~~Region 13 shall consist of the Counties of Mono, Inyo,~~
- 26 ~~and Imperial.~~
- 27 (xiv) ~~Region 14 shall consist of the County of Kern.~~
- 28 (xv)
- 29 (v) ~~Region 15 5 shall consist of the ZIP Codes in County of Los~~
- 30 ~~Angeles County starting with 906 to 912, inclusive, 915, 917, 918,~~
- 31 ~~and 935.~~
- 32 (xvi) ~~Region 16 shall consist of the ZIP Codes in Los Angeles~~
- 33 ~~County other than those identified in clause (xv).~~
- 34 (xvii)
- 35 (vi) ~~Region 17 6 shall consist of the Counties of Riverside, San~~
- 36 ~~Bernardino, and Riverside San Diego.~~
- 37 (xviii) ~~Region 18 shall consist of the County of Orange.~~
- 38 (xix) ~~Region 19 shall consist of the County of San Diego.~~
- 39 (B) *For the 2015 plan year and plan years thereafter, the*
- 40 *geographic regions for purposes of rating shall be the following,*

1 *subject to federal approval if required pursuant to Section 2701*
2 *of the federal Public Health Service Act (42 U.S.C. Sec. 300gg)*
3 *and obtained by the department and the Department of Insurance*
4 *by July 1, 2014:*

5 *(i) Region 1 shall consist of the Counties of Alpine, Amador,*
6 *Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake,*
7 *Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra,*
8 *Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.*

9 *(ii) Region 2 shall consist of the Counties of Marin, Napa,*
10 *Solano, and Sonoma.*

11 *(iii) Region 3 shall consist of the Counties of El Dorado, Placer,*
12 *Sacramento, and Yolo.*

13 *(iv) Region 4 shall consist of the Counties of Alameda, Contra*
14 *Costa, San Francisco, San Mateo, and Santa Clara.*

15 *(v) Region 5 shall consist of the Counties of Monterey, San*
16 *Benito, and Santa Cruz.*

17 *(vi) Region 6 shall consist of the Counties of Fresno, Kings,*
18 *Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.*

19 *(vii) Region 7 shall consist of the Counties of San Luis Obispo,*
20 *Santa Barbara, and Ventura.*

21 *(viii) Region 8 shall consist of the Counties of Imperial, Inyo,*
22 *Kern, and Mono.*

23 *(ix) Region 9 shall consist of the ZIP Codes in Los Angeles*
24 *County starting with 906 to 912, inclusive, 915, 917, 918, and 935.*

25 *(x) Region 10 shall consist of the ZIP Codes in Los Angeles*
26 *County other than those identified in clause (ix).*

27 *(xi) Region 11 shall consist of the Counties of Riverside and*
28 *San Bernardino.*

29 *(xii) Region 12 shall consist of the County of Orange.*

30 *(xiii) Region 13 shall consist of the County of San Diego.*

31 ~~(B)~~

32 *(C) No later than June 1, 2017, the department, in collaboration*
33 *with the Exchange and the Department of Insurance, shall review*
34 *the geographic rating regions specified in this paragraph and the*
35 *impacts of those regions on the health care coverage market in*
36 *California, and submit a report to the appropriate policy committees*
37 *of the Legislature.*

38 *(3) Whether the contract covers an individual or family, as*
39 *described in PPACA.*

1 (b) The rate for a health care service plan contract subject to
2 this section shall not vary by any factor not described in this
3 section.

4 (c) *The total premium charged to a small employer pursuant to*
5 *this section shall be determined by summing the premiums of*
6 *covered employees and dependents in accordance with Section*
7 *147.102(c)(1) of Title 45 of the Code of Federal Regulations.*

8 (e)

9 (d) The rating period for rates subject to this section shall be no
10 less than 12 months from the date of issuance or renewal of the
11 plan contract.

12 ~~(d) This section shall become inoperative if Section 2701 of~~
13 ~~the federal Public Health Service Act (42 U.S.C. Sec. 300gg), as~~
14 ~~added by Section 1201 of PPACA, is repealed, in which case rates~~
15 ~~for health care service plan contracts subject to this section shall~~
16 ~~instead be subject to Section 1357.12, to the extent permitted by~~
17 ~~federal law, and all references to this section shall be deemed to~~
18 ~~be references to Section 1357.12.~~

19 SEC. 8. Section 1363 of the Health and Safety Code is amended
20 to read:

21 1363. (a) The director shall require the use by each plan of
22 disclosure forms or materials containing information regarding
23 the benefits, services, and terms of the plan contract as the director
24 may require, so as to afford the public, subscribers, and enrollees
25 with a full and fair disclosure of the provisions of the plan in
26 readily understood language and in a clearly organized manner.
27 The director may require that the materials be presented in a
28 reasonably uniform manner so as to facilitate comparisons between
29 plan contracts of the same or other types of plans. Nothing
30 contained in this chapter shall preclude the director from permitting
31 the disclosure form to be included with the evidence of coverage
32 or plan contract.

33 The disclosure form shall provide for at least the following
34 information, in concise and specific terms, relative to the plan,
35 together with additional information as may be required by the
36 director, in connection with the plan or plan contract:

37 (1) The principal benefits and coverage of the plan, including
38 coverage for acute care and subacute care.

39 (2) The exceptions, reductions, and limitations that apply to the
40 plan.

1 (3) The full premium cost of the plan.

2 (4) Any copayment, coinsurance, or deductible requirements
3 that may be incurred by the member or the member's family in
4 obtaining coverage under the plan.

5 (5) The terms under which the plan may be renewed by the plan
6 member, including any reservation by the plan of any right to
7 change premiums.

8 (6) A statement that the disclosure form is a summary only, and
9 that the plan contract itself should be consulted to determine
10 governing contractual provisions. The first page of the disclosure
11 form shall contain a notice that conforms with all of the following
12 conditions:

13 (A) (i) States that the evidence of coverage discloses the terms
14 and conditions of coverage.

15 (ii) States, with respect to individual plan contracts, small group
16 plan contracts, and any other group plan contracts for which health
17 care services are not negotiated, that the applicant has a right to
18 view the evidence of coverage prior to enrollment, and, if the
19 evidence of coverage is not combined with the disclosure form,
20 the notice shall specify where the evidence of coverage can be
21 obtained prior to enrollment.

22 (B) Includes a statement that the disclosure and the evidence of
23 coverage should be read completely and carefully and that
24 individuals with special health care needs should read carefully
25 those sections that apply to them.

26 (C) Includes the plan's telephone number or numbers that may
27 be used by an applicant to receive additional information about
28 the benefits of the plan or a statement where the telephone number
29 or numbers are located in the disclosure form.

30 (D) For individual contracts, and small group plan contracts as
31 defined in Article 3.1 (commencing with Section 1357), the
32 disclosure form shall state where the health plan benefits and
33 coverage matrix is located.

34 (E) Is printed in type no smaller than that used for the remainder
35 of the disclosure form and is displayed prominently on the page.

36 (7) A statement as to when benefits shall cease in the event of
37 nonpayment of the prepaid or periodic charge and the effect of
38 nonpayment upon an enrollee who is hospitalized or undergoing
39 treatment for an ongoing condition.

1 (8) To the extent that the plan permits a free choice of provider
2 to its subscribers and enrollees, the statement shall disclose the
3 nature and extent of choice permitted and the financial liability
4 that is, or may be, incurred by the subscriber, enrollee, or a third
5 party by reason of the exercise of that choice.

6 (9) A summary of the provisions required by subdivision (g) of
7 Section 1373, if applicable.

8 (10) If the plan utilizes arbitration to settle disputes, a statement
9 of that fact.

10 (11) A summary of, and a notice of the availability of, the
11 process the plan uses to authorize, modify, or deny health care
12 services under the benefits provided by the plan, pursuant to
13 Sections 1363.5 and 1367.01.

14 (12) A description of any limitations on the patient’s choice of
15 primary care physician, specialty care physician, or nonphysician
16 health care practitioner, based on service area and limitations on
17 the patient’s choice of acute care hospital care, subacute or
18 transitional inpatient care, or skilled nursing facility.

19 (13) General authorization requirements for referral by a primary
20 care physician to a specialty care physician or a nonphysician
21 health care practitioner.

22 (14) Conditions and procedures for disenrollment.

23 (15) A description as to how an enrollee may request continuity
24 of care as required by Section 1373.96 and request a second opinion
25 pursuant to Section 1383.15.

26 (16) Information concerning the right of an enrollee to request
27 an independent review in accordance with Article 5.55
28 (commencing with Section 1374.30).

29 (17) A notice as required by Section 1364.5.

30 (b) (1) As of July 1, 1999, the director shall require each plan
31 offering a contract to an individual or small group to provide with
32 the disclosure form for individual and small group plan contracts
33 a uniform health plan benefits and coverage matrix containing the
34 plan’s major provisions in order to facilitate comparisons between
35 plan contracts. The uniform matrix shall include the following
36 category descriptions together with the corresponding copayments
37 and limitations in the following sequence:

38 (A) Deductibles.

39 (B) Lifetime maximums.

40 (C) Professional services.

- 1 (D) Outpatient services.
- 2 (E) Hospitalization services.
- 3 (F) Emergency health coverage.
- 4 (G) Ambulance services.
- 5 (H) Prescription drug coverage.
- 6 (I) Durable medical equipment.
- 7 (J) Mental health services.
- 8 (K) Chemical dependency services.
- 9 (L) Home health services.
- 10 (M) Other.

11 (2) The following statement shall be placed at the top of the
12 matrix in all capital letters in at least 10-point boldface type:

13
14 **THIS MATRIX IS INTENDED TO BE USED TO HELP YOU**
15 **COMPARE COVERAGE BENEFITS AND IS A SUMMARY**
16 **ONLY. THE EVIDENCE OF COVERAGE AND PLAN**
17 **CONTRACT SHOULD BE CONSULTED FOR A DETAILED**
18 **DESCRIPTION OF COVERAGE BENEFITS AND**
19 **LIMITATIONS.**

20
21 (c) Nothing in this section shall prevent a plan from using
22 appropriate footnotes or disclaimers to reasonably and fairly
23 describe coverage arrangements in order to clarify any part of the
24 matrix that may be unclear.

25 (d) All plans, solicitors, and representatives of a plan shall, when
26 presenting any plan contract for examination or sale to an
27 individual prospective plan member, provide the individual with
28 a properly completed disclosure form, as prescribed by the director
29 pursuant to this section for each plan so examined or sold.

30 (e) In the case of group contracts, the completed disclosure form
31 and evidence of coverage shall be presented to the contractholder
32 upon delivery of the completed health care service plan agreement.

33 (f) Group contractholders shall disseminate copies of the
34 completed disclosure form to all persons eligible to be a subscriber
35 under the group contract at the time those persons are offered the
36 plan. If the individual group members are offered a choice of plans,
37 separate disclosure forms shall be supplied for each plan available.
38 Each group contractholder shall also disseminate or cause to be
39 disseminated copies of the evidence of coverage to all applicants,

1 upon request, prior to enrollment and to all subscribers enrolled
2 under the group contract.

3 (g) In the case of conflicts between the group contract and the
4 evidence of coverage, the provisions of the evidence of coverage
5 shall be binding upon the plan notwithstanding any provisions in
6 the group contract that may be less favorable to subscribers or
7 enrollees.

8 (h) In addition to the other disclosures required by this section,
9 every health care service plan and any agent or employee of the
10 plan shall, when presenting a plan for examination or sale to any
11 individual purchaser or the representative of a group consisting of
12 25 or fewer individuals, disclose in writing the ratio of premium
13 costs to health services paid for plan contracts with individuals
14 and with groups of the same or similar size for the plan's preceding
15 fiscal year. A plan may report that information by geographic area,
16 provided the plan identifies the geographic area and reports
17 information applicable to that geographic area.

18 (i) Subdivision (b) shall not apply to any coverage provided by
19 a plan for the Medi-Cal program or the Medicare program pursuant
20 to Title XVIII and Title XIX of the Social Security Act.

21 (j) *Until January 1, 2015, the department may waive or modify*
22 *the requirements of this section for the purpose of resolving*
23 *duplication or conflict with federal requirements for uniform*
24 *benefit disclosure in effect pursuant to Section 2715 of the federal*
25 *Public Health Service Act and the regulations adopted thereunder.*
26 *The department shall implement this subdivision in a manner that*
27 *preserves disclosure requirements of this section that exceed or*
28 *are not in direct conflict with federal requirements.*
29 *Notwithstanding the Administrative Procedure Act (Chapter 3.5*
30 *(commencing with Section 11340) of Part 1 of Division 3 of Title*
31 *2 of the Government Code), the department shall implement this*
32 *subdivision through issuance of all-plan letters.*

33 SEC. 9. Section 1389.4 of the Health and Safety Code is
34 amended to read:

35 1389.4. (a) A full service health care service plan that issues,
36 renews, or amends individual health plan contracts shall be subject
37 to this section.

38 (b) A health care service plan subject to this section shall have
39 written policies, procedures, or underwriting guidelines establishing
40 the criteria and process whereby the plan makes its decision to

1 provide or to deny coverage to individuals applying for coverage
2 and sets the rate for that coverage. These guidelines, policies, or
3 procedures shall assure that the plan rating and underwriting criteria
4 comply with Sections 1365.5 and 1389.1 and all other applicable
5 provisions of state and federal law.

6 (c) On or before June 1, 2006, and annually thereafter, every
7 health care service plan shall file with the department a general
8 description of the criteria, policies, procedures, or guidelines the
9 plan uses for rating and underwriting decisions related to individual
10 health plan contracts, which means automatic declinable health
11 conditions, health conditions that may lead to a coverage decline,
12 height and weight standards, health history, health care utilization,
13 lifestyle, or behavior that might result in a decline for coverage or
14 severely limit the plan products for which they would be eligible.
15 A plan may comply with this section by submitting to the
16 department underwriting materials or resource guides provided to
17 plan solicitors or solicitor firms, provided that those materials
18 include the information required to be submitted by this section.

19 (d) Commencing January 1, 2011, the director shall post on the
20 department's Internet Web site, in a manner accessible and
21 understandable to consumers, general, noncompany specific
22 information about rating and underwriting criteria and practices
23 in the individual market and information about the California Major
24 Risk Medical Insurance Program (Part 6.5 (commencing with
25 Section 12700) of Division 2 of the Insurance Code) and the federal
26 temporary high risk pool established pursuant to Part 6.6
27 (commencing with Section 12739.5) of Division 2 of the Insurance
28 Code. The director shall develop the information for the Internet
29 Web site in consultation with the Department of Insurance to
30 enhance the consistency of information provided to consumers.
31 Information about individual health coverage shall also include
32 the following notification:

33 "Please examine your options carefully before declining group
34 coverage or continuation coverage, such as COBRA, that may be
35 available to you. You should be aware that companies selling
36 individual health insurance typically require a review of your
37 medical history that could result in a higher premium or you could
38 be denied coverage entirely."

1 (e) Nothing in this section shall authorize public disclosure of
2 company specific rating and underwriting criteria and practices
3 submitted to the director.

4 (f) This section shall not apply to a closed block of business, as
5 defined in Section 1367.15.

6 (g) *This section shall become inoperative on November 1, 2013,*
7 *or the 91st calendar day following the adjournment of the 2013–14*
8 *First Extraordinary Session, whichever date is later.*

9 SEC. 10. Section 1389.4 is added to the Health and Safety
10 Code, to read:

11 1389.4. (a) A full service health care service plan that renews
12 individual grandfathered health plans shall be subject to this
13 section.

14 (b) A health care service plan subject to this section shall have
15 written policies, procedures, or underwriting guidelines establishing
16 the criteria and process whereby the plan makes its decision to
17 provide or to deny coverage to individuals applying for an
18 individual grandfathered health plan and sets the rate for that
19 coverage. These guidelines, policies, or procedures shall ensure
20 that the plan rating and underwriting criteria comply with Sections
21 1365.5 and 1389.1 and all other applicable provisions of state and
22 federal law.

23 (c) On or before the June 1 next following the operative date of
24 this section, and annually thereafter, every health care service plan
25 shall file with the department a general description of the criteria,
26 policies, procedures, or guidelines the plan uses for rating and
27 underwriting decisions related to individual grandfathered health
28 plans, which means automatic declinable health conditions, health
29 conditions that may lead to a coverage decline, height and weight
30 standards, health history, health care utilization, lifestyle, or
31 behavior that might result in a decline for coverage or severely
32 limit the plan products for which they would be eligible. A plan
33 may comply with this section by submitting to the department
34 underwriting materials or resource guides provided to plan
35 solicitors or solicitor firms, provided that those materials include
36 the information required to be submitted by this section.

37 (d) Nothing in this section shall authorize public disclosure of
38 company specific rating and underwriting criteria and practices
39 submitted to the director.

1 (e) This section shall not apply to a closed block of business,
2 as defined in Section 1367.15.

3 (f) For purposes of this section, the following definitions shall
4 apply:

5 (1) “PPACA” means the federal Patient Protection and
6 Affordable Care Act (Public Law 111-148), as amended by the
7 federal Health Care and Education Reconciliation Act of 2010
8 (Public Law 111-152), and any rules, regulations, or guidance
9 issued pursuant to that law.

10 (2) “Grandfathered health plan” has the same meaning as that
11 term is defined in Section 1251 of PPACA.

12 (g) This section shall become operative on November 1, 2013,
13 or the 91st calendar day following the adjournment of the 2013–14
14 First Extraordinary Session, whichever date is later.

15 SEC. 11. Section 1389.5 of the Health and Safety Code is
16 amended to read:

17 1389.5. (a) This section shall apply to a health care service
18 plan that provides coverage under an individual plan contract that
19 is issued, amended, delivered, or renewed on or after January 1,
20 2007.

21 (b) At least once each year, the health care service plan shall
22 permit an individual who has been covered for at least 18 months
23 under an individual plan contract to transfer, without medical
24 underwriting, to any other individual plan contract offered by that
25 same health care service plan that provides equal or lesser benefits,
26 as determined by the plan.

27 “Without medical underwriting” means that the health care
28 service plan shall not decline to offer coverage to, or deny
29 enrollment of, the individual or impose any preexisting condition
30 exclusion on the individual who transfers to another individual
31 plan contract pursuant to this section.

32 (c) The plan shall establish, for the purposes of subdivision (b),
33 a ranking of the individual plan contracts it offers to individual
34 purchasers and post the ranking on its Internet Web site or make
35 the ranking available upon request. The plan shall update the
36 ranking whenever a new benefit design for individual purchasers
37 is approved.

38 (d) The plan shall notify in writing all enrollees of the right to
39 transfer to another individual plan contract pursuant to this section,
40 at a minimum, when the plan changes the enrollee’s premium rate.

1 Posting this information on the plan’s Internet Web site shall not
2 constitute notice for purposes of this subdivision. The notice shall
3 adequately inform enrollees of the transfer rights provided under
4 this section, including information on the process to obtain details
5 about the individual plan contracts available to that enrollee and
6 advising that the enrollee may be unable to return to his or her
7 current individual plan contract if the enrollee transfers to another
8 individual plan contract.

9 (e) The requirements of this section shall not apply to the
10 following:

11 (1) A federally eligible defined individual, as defined in
12 subdivision (c) of Section 1399.801, who is enrolled in an
13 individual health benefit plan contract offered pursuant to Section
14 1366.35.

15 (2) An individual offered conversion coverage pursuant to
16 Section 1373.6.

17 (3) Individual coverage under a specialized health care service
18 plan contract.

19 (4) An individual enrolled in the Medi-Cal program pursuant
20 to Chapter 7 (commencing with Section 14000) of Division 9 of
21 Part 3 of the Welfare and Institutions Code.

22 (5) An individual enrolled in the Access for Infants and Mothers
23 Program pursuant to Part 6.3 (commencing with Section 12695)
24 of Division 2 of the Insurance Code.

25 (6) An individual enrolled in the Healthy Families Program
26 pursuant to Part 6.2 (commencing with Section 12693) of Division
27 2 of the Insurance Code.

28 (f) It is the intent of the Legislature that individuals shall have
29 more choice in their health coverage when health care service plans
30 guarantee the right of an individual to transfer to another product
31 based on the plan’s own ranking system. The Legislature does not
32 intend for the department to review or verify the plan’s ranking
33 for actuarial or other purposes.

34 (g) *This section shall remain in effect only until January 1, 2014,*
35 *or the 91st calendar day following the adjournment of the 2013–14*
36 *First Extraordinary Session, whichever date is later, and as of*
37 *that date is repealed, unless a later enacted statute, that becomes*
38 *operative on or before that date, deletes or extends the date on*
39 *which it is repealed.*

1 SEC. 12. Section 1389.7 of the Health and Safety Code is
2 amended to read:

3 1389.7. (a) Every health care service plan that offers, issues,
4 or renews individual plan contracts shall offer to any individual,
5 who was covered under an individual plan contract that was
6 rescinded, a new individual plan contract, without medical
7 underwriting, that provides equal benefits. A health care service
8 plan may also permit an individual, who was covered under an
9 individual plan contract that was rescinded, to remain covered
10 under that individual plan contract, with a revised premium rate
11 that reflects the number of persons remaining on the plan contract.

12 (b) “Without medical underwriting” means that the health care
13 service plan shall not decline to offer coverage to, or deny
14 enrollment of, the individual or impose any preexisting condition
15 exclusion on the individual who is issued a new individual plan
16 contract or remains covered under an individual plan contract
17 pursuant to this section.

18 (c) If a new individual plan contract is issued, the plan may
19 revise the premium rate to reflect only the number of persons
20 covered on the new individual plan contract.

21 (d) Notwithstanding subdivision (a) and (b), if an individual
22 was subject to a preexisting condition provision or a waiting or an
23 affiliation period under the individual plan contract that was
24 rescinded, the health care service plan may apply the same
25 preexisting condition provision or waiting or affiliation period in
26 the new individual plan contract. The time period in the new
27 individual plan contract for the preexisting condition provision or
28 waiting or affiliation period shall not be longer than the one in the
29 individual plan contract that was rescinded and the health care
30 service plan shall credit any time that the individual was covered
31 under the rescinded individual plan contract.

32 (e) The plan shall notify in writing all enrollees of the right to
33 coverage under an individual plan contract pursuant to this section,
34 at a minimum, when the plan rescinds the individual plan contract.
35 The notice shall adequately inform enrollees of the right to
36 coverage provided under this section.

37 (f) The plan shall provide 60 days for enrollees to accept the
38 offered new individual plan contract and this contract shall be
39 effective as of the effective date of the original plan contract and
40 there shall be no lapse in coverage.

1 (g) This section shall not apply to any individual whose
2 information in the application for coverage and related
3 communications led to the rescission.

4 (h) *This section shall become inoperative on January 1, 2014,*
5 *or the 91st calendar day following the adjournment of the 2013–14*
6 *First Extraordinary Session, whichever date is later.*

7 SEC. 13. Section 1389.7 is added to the Health and Safety
8 Code, to read:

9 1389.7. (a) Every health care service plan that offers, issues,
10 or renews individual plan contracts shall offer to any individual,
11 who was covered by the plan under an individual plan contract
12 that was rescinded, a new individual plan contract that provides
13 the most equivalent benefits.

14 (b) If a new individual plan contract is issued under subdivision
15 (a), the plan may revise the premium rate to reflect only the number
16 of persons covered on the new individual plan contract consistent
17 with Section 1399.855.

18 (c) The plan shall notify in writing all enrollees of the right to
19 coverage under an individual plan contract pursuant to this section,
20 at a minimum, when the plan rescinds the individual plan contract.
21 The notice shall adequately inform enrollees of the right to
22 coverage provided under this section.

23 (d) The plan shall provide 60 days for enrollees to accept the
24 offered new individual plan contract under subdivision (a), and
25 this contract shall be effective as of the effective date of the original
26 plan contract and there shall be no lapse in coverage.

27 (e) This section shall not apply to any individual whose
28 information in the application for coverage and related
29 communications led to the rescission.

30 (f) This section shall apply notwithstanding subdivision (a) or
31 (d) of Section 1399.849.

32 (g) This section shall become operative on January 1, 2014, or
33 the 91st calendar day following the adjournment of the 2013–14
34 First Extraordinary Session, whichever date is later.

35 SEC. 14. Section 1399.805 of the Health and Safety Code is
36 amended to read:

37 1399.805. (a) (1) After the federally eligible defined individual
38 submits a completed application form for a plan contract, the plan
39 shall, within 30 days, notify the individual of the individual's actual
40 premium charges for that plan contract, unless the plan has

1 provided notice of the premium charge prior to the application
2 being filed. In no case shall the premium charged for any health
3 care service plan contract identified in subdivision (d) of Section
4 1366.35 exceed the following amounts:

5 (A) For health care service plan contracts that offer services
6 through a preferred provider arrangement, the average premium
7 paid by a subscriber of the Major Risk Medical Insurance Program
8 who is of the same age and resides in the same geographic area as
9 the federally eligible defined individual. However, for federally
10 qualified individuals who are between the ages of 60 and 64,
11 inclusive, the premium shall not exceed the average premium paid
12 by a subscriber of the Major Risk Medical Insurance Program who
13 is 59 years of age and resides in the same geographic area as the
14 federally eligible defined individual.

15 (B) For health care service plan contracts identified in
16 subdivision (d) of Section 1366.35 that do not offer services
17 through a preferred provider arrangement, 170 percent of the
18 standard premium charged to an individual who is of the same age
19 and resides in the same geographic area as the federally eligible
20 defined individual. However, for federally qualified individuals
21 who are between the ages of 60 and 64, inclusive, the premium
22 shall not exceed 170 percent of the standard premium charged to
23 an individual who is 59 years of age and resides in the same
24 geographic area as the federally eligible defined individual. The
25 individual shall have 30 days in which to exercise the right to buy
26 coverage at the quoted premium rates.

27 (2) A plan may adjust the premium based on family size, not to
28 exceed the following amounts:

29 (A) For health care service plans that offer services through a
30 preferred provider arrangement, the average of the Major Risk
31 Medical Insurance Program rate for families of the same size that
32 reside in the same geographic area as the federally eligible defined
33 individual.

34 (B) For health care service plans identified in subdivision (d)
35 of Section 1366.35 that do not offer services through a preferred
36 provider arrangement, 170 percent of the standard premium charged
37 to a family that is of the same size and resides in the same
38 geographic area as the federally eligible defined individual.

39 (b) When a federally eligible defined individual submits a
40 premium payment, based on the quoted premium charges, and that

1 payment is delivered or postmarked, whichever occurs earlier,
2 within the first 15 days of the month, coverage shall begin no later
3 than the first day of the following month. When that payment is
4 neither delivered or postmarked until after the 15th day of a month,
5 coverage shall become effective no later than the first day of the
6 second month following delivery or postmark of the payment.

7 (c) During the first 30 days after the effective date of the plan
8 contract, the individual shall have the option of changing coverage
9 to a different plan contract offered by the same health care service
10 plan. If the individual notified the plan of the change within the
11 first 15 days of a month, coverage under the new plan contract
12 shall become effective no later than the first day of the following
13 month. If an enrolled individual notified the plan of the change
14 after the 15th day of a month, coverage under the new plan contract
15 shall become effective no later than the first day of the second
16 month following notification.

17 (d) *This section shall remain in effect only until January 1, 2014,*
18 *or the 91st calendar day following the adjournment of the 2013–14*
19 *First Extraordinary Session, whichever date is later, and as of*
20 *that date is repealed, unless a later enacted statute, that becomes*
21 *operative on or before that date, deletes or extends the date on*
22 *which it is repealed.*

23 SEC. 15. Section 1399.805 is added to the Health and Safety
24 Code, to read:

25 1399.805. (a) After the federally eligible defined individual
26 submits a completed application form for a plan contract, the plan
27 shall, within 30 days, notify the individual of the individual's actual
28 premium charges for that plan contract, unless the plan has
29 provided notice of the premium charge prior to the application
30 being filed. In no case shall the premium charged for any health
31 care service plan contract identified in subdivision (d) of Section
32 1366.35 exceed the premium for the second lowest cost silver plan
33 of the individual market in the rating area in which the individual
34 resides which is offered through the California Health Benefit
35 Exchange established under Title 22 (commencing with Section
36 100500) of the Government Code, as described in Section
37 36B(b)(3)(B) of Title 26 of the United States Code.

38 (b) When a federally eligible defined individual submits a
39 premium payment, based on the quoted premium charges, and that
40 payment is delivered or postmarked, whichever occurs earlier,

1 within the first 15 days of the month, coverage shall begin no later
2 than the first day of the following month. When that payment is
3 neither delivered nor postmarked until after the 15th day of a
4 month, coverage shall become effective no later than the first day
5 of the second month following delivery or postmark of the
6 payment.

7 (c) During the first 30 days after the effective date of the plan
8 contract, the individual shall have the option of changing coverage
9 to a different plan contract offered by the same health care service
10 plan. If the individual notified the plan of the change within the
11 first 15 days of a month, coverage under the new plan contract
12 shall become effective no later than the first day of the following
13 month. If an enrolled individual notified the plan of the change
14 after the 15th day of a month, coverage under the new plan contract
15 shall become effective no later than the first day of the second
16 month following notification.

17 (d) This section shall become operative on January 1, 2014, or
18 the 91st calendar day following the adjournment of the 2013–14
19 First Extraordinary Session, whichever date is later.

20 SEC. 16. Section 1399.811 of the Health and Safety Code is
21 amended to read:

22 1399.811. Premiums for contracts offered, delivered, amended,
23 or renewed by plans on or after January 1, 2001, shall be subject
24 to the following requirements:

25 (a) The premium for new business for a federally eligible defined
26 individual shall not exceed the following amounts:

27 (1) For health care service plan contracts identified in
28 subdivision (d) of Section 1366.35 that offer services through a
29 preferred provider arrangement, the average premium paid by a
30 subscriber of the Major Risk Medical Insurance Program who is
31 of the same age and resides in the same geographic area as the
32 federally eligible defined individual. However, for federally
33 qualified individuals who are between the ages of 60 to 64 years,
34 inclusive, the premium shall not exceed the average premium paid
35 by a subscriber of the Major Risk Medical Insurance Program who
36 is 59 years of age and resides in the same geographic area as the
37 federally eligible defined individual.

38 (2) For health care service plan contracts identified in
39 subdivision (d) of Section 1366.35 that do not offer services
40 through a preferred provider arrangement, 170 percent of the

1 standard premium charged to an individual who is of the same age
2 and resides in the same geographic area as the federally eligible
3 defined individual. However, for federally qualified individuals
4 who are between the ages of 60 to 64 years, inclusive, the premium
5 shall not exceed 170 percent of the standard premium charged to
6 an individual who is 59 years of age and resides in the same
7 geographic area as the federally eligible defined individual.

8 (b) The premium for in force business for a federally eligible
9 defined individual shall not exceed the following amounts:

10 (1) For health care service plan contracts identified in
11 subdivision (d) of Section 1366.35 that offer services through a
12 preferred provider arrangement, the average premium paid by a
13 subscriber of the Major Risk Medical Insurance Program who is
14 of the same age and resides in the same geographic area as the
15 federally eligible defined individual. However, for federally
16 qualified individuals who are between the ages of 60 and 64 years,
17 inclusive, the premium shall not exceed the average premium paid
18 by a subscriber of the Major Risk Medical Insurance Program who
19 is 59 years of age and resides in the same geographic area as the
20 federally eligible defined individual.

21 (2) For health care service plan contracts identified in
22 subdivision (d) of Section 1366.35 that do not offer services
23 through a preferred provider arrangement, 170 percent of the
24 standard premium charged to an individual who is of the same age
25 and resides in the same geographic area as the federally eligible
26 defined individual. However, for federally qualified individuals
27 who are between the ages of 60 and 64 years, inclusive, the
28 premium shall not exceed 170 percent of the standard premium
29 charged to an individual who is 59 years of age and resides in the
30 same geographic area as the federally eligible defined individual.

31 The premium effective on January 1, 2001, shall apply to in force
32 business at the earlier of either the time of renewal or July 1, 2001.

33 (c) The premium applied to a federally eligible defined
34 individual may not increase by more than the following amounts:

35 (1) For health care service plan contracts identified in
36 subdivision (d) of Section 1366.35 that offer services through a
37 preferred provider arrangement, the average increase in the
38 premiums charged to a subscriber of the Major Risk Medical
39 Insurance Program who is of the same age and resides in the same
40 geographic area as the federally eligible defined individual.

1 (2) For health care service plan contracts identified in
2 subdivision (d) of Section 1366.35 that do not offer services
3 through a preferred provider arrangement, the increase in premiums
4 charged to a nonfederally qualified individual who is of the same
5 age and resides in the same geographic area as the federally defined
6 eligible individual. The premium for an eligible individual may
7 not be modified more frequently than every 12 months.

8 (3) For a contract that a plan has discontinued offering, the
9 premium applied to the first rating period of the new contract that
10 the federally eligible defined individual elects to purchase shall
11 be no greater than the premium applied in the prior rating period
12 to the discontinued contract.

13 *(d) This section shall remain in effect only until January 1, 2014,*
14 *or the 91st calendar day following the adjournment of the 2013–14*
15 *First Extraordinary Session, whichever date is later, and as of*
16 *that date is repealed, unless a later enacted statute, that becomes*
17 *operative on or before that date, deletes or extends the date on*
18 *which it is repealed.*

19 SEC. 17. Section 1399.811 is added to the Health and Safety
20 Code, to read:

21 1399.811. (a) Premiums for contracts offered, delivered,
22 amended, or renewed by plans on or after the operative date of
23 this section shall be subject to the following requirements:

24 (1) The premium for in force or new business for a federally
25 eligible defined individual shall not exceed the premium for the
26 second lowest cost silver plan of the individual market in the rating
27 area in which the individual resides which is offered through the
28 California Health Benefit Exchange established under Title 22
29 (commencing with Section 100500) of the Government Code, as
30 described in Section 36B(b)(3)(B) of Title 26 of the United States
31 Code.

32 (2) For a contract that a plan has discontinued offering, the
33 premium applied to the first rating period of the new contract that
34 the federally eligible defined individual elects to purchase shall
35 be no greater than the premium applied in the prior rating period
36 to the discontinued contract.

37 (b) This section shall become operative on January 1, 2014, or
38 the 91st calendar day following the adjournment of the 2013–14
39 First Extraordinary Session, whichever date is later.

1 SEC. 18. Section 1399.816 of the Health and Safety Code is
2 repealed.

3 ~~1399.816. Carriers and health care service plans that offer~~
4 ~~contracts to individuals may elect to establish a mechanism or~~
5 ~~method to share in the financing of high-risk individuals. This~~
6 ~~mechanism or method shall be established through a committee~~
7 ~~of all carriers and health care service plans offering coverage to~~
8 ~~individuals by July 1, 2002, and shall be implemented by January~~
9 ~~1, 2003. If carriers and health care service plans wish to establish~~
10 ~~a risk-sharing mechanism but cannot agree on the terms and~~
11 ~~conditions of such an agreement, the Managed Risk Medical~~
12 ~~Insurance Board shall develop a risk-sharing mechanism or method~~
13 ~~by January 1, 2003, and it shall be implemented by July 1, 2003.~~

14 SEC. 19. The heading of Article 11.7 (commencing with
15 Section 1399.825) of Chapter 2.2 of Division 2 of the Health and
16 Safety Code is amended to read:

17
18 Article 11.7. ~~Individual~~ Child Access to Health Care Coverage

19
20 SEC. 20. Section 1399.829 of the Health and Safety Code is
21 amended to read:

22 1399.829. (a) A health care service plan may use the following
23 characteristics of an eligible child for purposes of establishing the
24 rate of the plan contract for that child, where consistent with federal
25 regulations under PPACA: age, geographic region, and family
26 composition, plus the health care service plan contract selected by
27 the child or the responsible party for the child.

28 (b) From the effective date of this article to December 31, 2013,
29 inclusive, rates for a child applying for coverage shall be subject
30 to the following limitations:

31 (1) During any open enrollment period or for late enrollees, the
32 rate for any child due to health status shall not be more than two
33 times the standard risk rate for a child.

34 (2) The rate for a child shall be subject to a 20-percent surcharge
35 above the highest allowable rate on a child applying for coverage
36 who is not a late enrollee and who failed to maintain coverage with
37 any health care service plan or health insurer for the 90-day period
38 prior to the date of the child’s application. The surcharge shall
39 apply for the 12-month period following the effective date of the
40 child’s coverage.

1 (3) If expressly permitted under PPACA and any rules,
2 regulations, or guidance issued pursuant to that act, a health care
3 service plan may rate a child based on health status during any
4 period other than an open enrollment period if the child is not a
5 late enrollee.

6 (4) If expressly permitted under PPACA and any rules,
7 regulations, or guidance issued pursuant to that act, a health care
8 service plan may condition an offer or acceptance of coverage on
9 any preexisting condition or other health status-related factor for
10 a period other than an open enrollment period and for a child who
11 is not a late enrollee.

12 (c) For any individual health care service plan contract issued,
13 sold, or renewed prior to December 31, 2013, the health plan shall
14 provide to a child or responsible party for a child a notice that
15 states the following:

16
17 “Please consider your options carefully before failing to maintain
18 or ~~renew~~ *renewing* coverage for a child for whom you are
19 responsible. If you attempt to obtain new individual coverage for
20 that child, the premium for the same coverage may be higher than
21 the premium you pay now.”

22
23 (d) A child who applied for coverage between September 23,
24 2010, and the end of the initial open enrollment period shall be
25 deemed to have maintained coverage during that period.

26 (e) Effective January 1, 2014, except for individual
27 grandfathered health plan coverage, the rate for any child shall be
28 identical to the standard risk rate.

29 (f) Health care service plans ~~may~~ *shall not* require
30 documentation from applicants relating to their coverage history.

31 (g) (1) *On and after the operative date of the act adding this*
32 *subdivision, and until January 1, 2014, a health care service plan*
33 *shall provide a notice to all applicants for coverage under this*
34 *article and to all enrollees, or the responsible party for an enrollee,*
35 *renewing coverage under this article that contains the following*
36 *information:*

37 (A) *Information about the open enrollment period provided*
38 *under Section 1399.849.*

39 (B) *An explanation that obtaining coverage during the open*
40 *enrollment period described in Section 1399.849 will not affect*

1 *the effective dates of coverage for coverage purchased pursuant*
2 *to this article unless the applicant cancels that coverage.*

3 *(C) An explanation that coverage purchased pursuant to this*
4 *article shall be effective as required under subdivision (d) of*
5 *Section 1399.826 and that such coverage shall not prevent an*
6 *applicant from obtaining new coverage during the open enrollment*
7 *period described in Section 1399.849.*

8 *(D) Information about the Medi-Cal program and the Healthy*
9 *Families Program and about subsidies available through the*
10 *California Health Benefit Exchange.*

11 *(2) The notice described in paragraph (1) shall be in plain*
12 *language and 14-point type.*

13 *(3) The department may adopt a model notice to be used by*
14 *health care service plans in order to comply with this subdivision,*
15 *and shall consult with the Department of Insurance in adopting*
16 *that model notice. Use of the model notice shall not require prior*
17 *approval of the department. Any model notice designated by the*
18 *department for purposes of this section shall not be subject to the*
19 *Administrative Procedure Act (Chapter 3.5 (commencing with*
20 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*
21 *Code).*

22 SEC. 21. Section 1399.836 is added to the Health and Safety
23 Code, to read:

24 1399.836. This article shall become inoperative on January 1,
25 2014, or the 91st calendar day following the adjournment of the
26 2013–14 First Extraordinary Session, whichever date is later.

27 SEC. 22. Article 11.8 (commencing with Section 1399.845)
28 is added to Chapter 2.2 of Division 2 of the Health and Safety
29 Code, to read:

30

31 Article 11.8. Individual Access to Health Care Coverage

32

33 1399.845. For purposes of this article, the following definitions
34 shall apply:

35 (a) “Child” means a child described in Section 22775 of the
36 Government Code and subdivisions (n) to (p), inclusive, of Section
37 599.500 of Title 2 of the California Code of Regulations.

38 (b) “Dependent” means the spouse or registered domestic
39 partner, or child, of an individual, subject to applicable terms of
40 the health benefit plan.

1 (c) “Exchange” means the California Health Benefit Exchange
2 created by Section 100500 of the Government Code.

3 (d) “Grandfathered health plan” has the same meaning as that
4 term is defined in Section 1251 of PPACA.

5 (e) “Health benefit plan” means any individual or group health
6 care service plan contract that provides medical, hospital, and
7 surgical benefits. The term does not include a specialized health
8 care service plan contract, a health care service plan conversion
9 contract offered pursuant to Section 1373.6, a health care service
10 plan contract provided in the Medi-Cal program (Chapter 7
11 (commencing with Section 14000) of Part 3 of Division 9 of the
12 Welfare and Institutions Code), the Healthy Families Program
13 (Part 6.2 (commencing with Section 12693) of Division 2 of the
14 Insurance Code), the Access for Infants and Mothers Program
15 (Part 6.3 (commencing with Section 12695) of Division 2 of the
16 Insurance Code), or the program under Part 6.4 (commencing with
17 Section 12699.50) of Division 2 of the Insurance Code, a health
18 care service plan contract offered to a federally eligible defined
19 individual under Article 4.6 (commencing with Section 1366.35),
20 or Medicare supplement coverage, to the extent consistent with
21 PPACA.

22 (f) “Policy year” has the meaning set forth in Section 144.103
23 of Title 45 of the Code of Federal Regulations.

24 (g) “PPACA” means the federal Patient Protection and
25 Affordable Care Act (Public Law 111-148), as amended by the
26 federal Health Care and Education Reconciliation Act of 2010
27 (Public Law 111-152), and any rules, regulations, or guidance
28 issued pursuant to that law.

29 (h) “Preexisting condition provision” means a contract provision
30 that excludes coverage for charges or expenses incurred during a
31 specified period following the enrollee’s effective date of coverage,
32 as to a condition for which medical advice, diagnosis, care, or
33 treatment was recommended or received during a specified period
34 immediately preceding the effective date of coverage.

35 (i) “Rating period” means the period for which premium rates
36 established by a plan are in effect.

37 (j) “Registered domestic partner” means a person who has
38 established a domestic partnership as described in Section 297 of
39 the Family Code.

1 1399.847. Every health care service plan offering individual
2 health benefit plans shall, in addition to complying with the
3 provisions of this chapter and rules adopted thereunder, comply
4 with the provisions of this article.

5 1399.849. (a) (1) On and after October 1, 2013, a plan shall
6 fairly and affirmatively offer, market, and sell all of the plan's
7 health benefit plans that are sold in the individual market for policy
8 years on or after January 1, 2014, to all individuals and dependents
9 in each service area in which the plan provides or arranges for the
10 provision of health care services. A plan shall limit enrollment in
11 individual health benefit plans to open enrollment periods and
12 special enrollment periods as provided in subdivisions (c) and (d).

13 (2) A plan shall allow the subscriber of an individual health
14 benefit plan to add a dependent to the subscriber's plan at the
15 option of the subscriber, consistent with the open enrollment,
16 annual enrollment, and special enrollment period requirements in
17 this section.

18 (3) A health care service plan offering coverage in the individual
19 market shall not reject the request of a subscriber during an open
20 enrollment period to include a dependent of the subscriber as a
21 dependent on an existing individual health benefit plan.

22 (b) An individual health benefit plan issued, amended, or
23 renewed on or after January 1, 2014, shall not impose any
24 preexisting condition provision upon any individual.

25 (c) A plan shall provide an initial open enrollment period from
26 October 1, 2013, to March 31, 2014, inclusive, and annual
27 enrollment periods for plan years on or after January 1, 2015, from
28 October 15 to December 7, inclusive, of the preceding calendar
29 year.

30 (d) (1) Subject to paragraph (2), commencing January 1, 2014,
31 a plan shall allow an individual to enroll in or change individual
32 health benefit plans as a result of the following triggering events:

33 (A) He or she or his or her dependent loses minimum essential
34 coverage. For purposes of this paragraph, the following definitions
35 shall apply:

36 (i) "Minimum essential coverage" has the same meaning as that
37 term is defined in subsection (f) of Section 5000A of the Internal
38 Revenue Code (26 U.S.C. Sec. 5000A).

39 (ii) "Loss of minimum essential coverage" includes, but is not
40 limited to, loss of that coverage due to the circumstances described

1 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
2 Code of Federal Regulations and the circumstances described in
3 Section 1163 of Title 29 of the United States Code. “Loss of
4 minimum essential coverage” also includes loss of that coverage
5 for a reason that is not due to the fault of the individual.

6 (iii) “Loss of minimum essential coverage” does not include
7 loss of that coverage due to the individual’s failure to pay
8 premiums on a timely basis or situations allowing for a rescission,
9 subject to clause (ii) and Sections 1389.7 and 1389.21.

10 (B) He or she gains a dependent or becomes a dependent.

11 (C) He or she is mandated to be covered pursuant to a valid
12 state or federal court order.

13 (D) He or she has been released from incarceration.

14 (E) His or her health benefit plan substantially violated a
15 material provision of the contract.

16 (F) He or she gains access to new health benefit plans as a result
17 of a permanent move.

18 (G) He or she was receiving services from a contracting provider
19 under another health benefit plan, as defined in Section 1399.845
20 or Section 10965 of the Insurance Code, for one of the conditions
21 described in subdivision (c) of Section 1373.96 and that provider
22 is no longer participating in the health benefit plan.

23 (H) He or she demonstrates to the Exchange, with respect to
24 health benefit plans offered through the Exchange, or to the
25 department, with respect to health benefit plans offered outside
26 the Exchange, that he or she did not enroll in a health benefit plan
27 during the immediately preceding enrollment period available to
28 the individual because he or she was misinformed that he or she
29 was covered under minimum essential coverage.

30 (I) With respect to individual health benefit plans offered
31 through the Exchange, in addition to the triggering events listed
32 in this paragraph, any other events listed in Section 155.420(d) of
33 Title 45 of the Code of Federal Regulations.

34 (2) With respect to individual health benefit plans offered
35 outside the Exchange, an individual shall have 63 days from the
36 date of a triggering event identified in paragraph (1) to apply for
37 coverage from a health care service plan subject to this section.
38 With respect to individual health benefit plans offered through the
39 Exchange, an individual shall have 63 days from the date of a
40 triggering event identified in paragraph (1) to select a plan offered

1 through the Exchange, unless a longer period is provided in Part
2 155 (commencing with Section 155.10) of Subchapter B of Subtitle
3 A of Title 45 of the Code of Federal Regulations.

4 (e) With respect to individual health benefit plans offered
5 through the Exchange, the following provisions shall apply:

6 (1) The effective date of coverage selected pursuant to this
7 section shall be consistent with the dates specified in Section
8 155.410 or 155.420 of Title 45 of the Code of Federal Regulations.

9 (2) Notwithstanding paragraph (1), in the case where an
10 individual acquires or becomes a dependent by entering into a
11 registered domestic partnership pursuant to Section 297 of the
12 Family Code and applies for coverage of that domestic partner
13 consistent with subdivision (d), the coverage effective date shall
14 be the first day of the month following the date he or she selects
15 a plan through the Exchange, unless an earlier date is agreed to
16 under Section 155.420(b)(3) of Title 45 of the Code of Federal
17 Regulations.

18 (f) With respect to individual health benefit plans offered outside
19 the Exchange, the following provisions shall apply:

20 (1) After an individual submits a completed application form
21 for a plan contract, the health care service plan shall, within 30
22 days, notify the individual of the individual's actual premium
23 charges for that plan established in accordance with Section
24 1399.855. The individual shall have 30 days in which to exercise
25 the right to buy coverage at the quoted premium charges.

26 (2) With respect to an individual health benefit plan for which
27 an individual applies during the initial open enrollment period
28 described in subdivision (c), when the subscriber submits a
29 premium payment, based on the quoted premium charges, and that
30 payment is delivered or postmarked, whichever occurs earlier, by
31 December 15, 2013, coverage under the individual health benefit
32 plan shall become effective no later than January 1, 2014. When
33 that payment is delivered or postmarked within the first 15 days
34 of any subsequent month, coverage shall become effective no later
35 than the first day of the following month. When that payment is
36 delivered or postmarked between December 16, 2013, and
37 December 31, 2013, inclusive, or after the 15th day of any
38 subsequent month, coverage shall become effective no later than
39 the first day of the second month following delivery or postmark
40 of the payment.

1 (3) With respect to an individual health benefit plan for which
2 an individual applies during the annual open enrollment period
3 described in subdivision (c), when the individual submits a
4 premium payment, based on the quoted premium charges, and that
5 payment is delivered or postmarked, whichever occurs later, by
6 December 15, coverage shall become effective as of the following
7 January 1. When that payment is delivered or postmarked within
8 the first 15 days of any subsequent month, coverage shall become
9 effective no later than the first day of the following month. When
10 that payment is delivered or postmarked between December 16
11 and December 31, inclusive, or after the 15th day of any subsequent
12 month, coverage shall become effective no later than the first day
13 of the second month following delivery or postmark of the
14 payment.

15 (4) With respect to an individual health benefit plan for which
16 an individual applies during a special enrollment period described
17 in subdivision (d), the following provisions shall apply:

18 (A) When the individual submits a premium payment, based
19 on the quoted premium charges, and that payment is delivered or
20 postmarked, whichever occurs earlier, within the first 15 days of
21 the month, coverage under the plan shall become effective no later
22 than the first day of the following month. When the premium
23 payment is neither delivered nor postmarked until after the 15th
24 day of the month, coverage shall become effective no later than
25 the first day of the second month following delivery or postmark
26 of the payment.

27 (B) Notwithstanding subparagraph (A), in the case of a birth,
28 adoption, or placement for adoption, the coverage shall be effective
29 on the date of birth, adoption, or placement for adoption.

30 (C) Notwithstanding subparagraph (A), in the case of marriage
31 or becoming a registered domestic partner or in the case where a
32 qualified individual loses minimum essential coverage, the
33 coverage effective date shall be the first day of the month following
34 the date the plan receives the request for special enrollment.

35 (g) (1) A health care service plan shall not establish rules for
36 eligibility, including continued eligibility, of any individual to
37 enroll under the terms of an individual health benefit plan based
38 on any of the following factors:

39 (A) Health status.

40 (B) Medical condition, including physical and mental illnesses.

- 1 (C) Claims experience.
- 2 (D) Receipt of health care.
- 3 (E) Medical history.
- 4 (F) Genetic information.
- 5 (G) Evidence of insurability, including conditions arising out
- 6 of acts of domestic violence.
- 7 (H) Disability.
- 8 (I) Any other health status-related factor as determined by any
- 9 federal regulations, rules, or guidance issued pursuant to Section
- 10 2705 of the federal Public Health Service Act.

11 (2) Notwithstanding Section 1389.1, a health care service plan
 12 shall not require an individual applicant or his or her dependent
 13 to fill out a health assessment or medical questionnaire prior to
 14 enrollment under an individual health benefit plan. A health care
 15 service plan shall not acquire or request information that relates
 16 to a health status-related factor from the applicant or his or her
 17 dependent or any other source prior to enrollment of the individual.

18 (h) (1) A health care service plan shall consider the claims
 19 experience of all enrollees in all individual health benefit plans
 20 offered in the state that are subject to subdivision (a), including
 21 those enrollees who do not enroll in the plans through the
 22 Exchange, to be members of a single risk pool.

23 (2) Each policy year, a health care service plan shall establish
 24 an index rate for the individual market in the state based on the
 25 total combined claims costs for providing essential health benefits,
 26 as defined pursuant to Section 1302 of PPACA, within the single
 27 risk pool required under paragraph (1). The index rate shall be
 28 adjusted on a market-wide basis based on the total expected
 29 market-wide payments and charges under the risk adjustment and
 30 reinsurance programs established for the state pursuant to Sections
 31 1343 and 1341 of PPACA. The premium rate for all of the health
 32 care service plan’s health benefit plans in the individual market
 33 shall use the applicable index rate, as adjusted for total expected
 34 market-wide payments and charges under the risk adjustment and
 35 reinsurance programs established for the state pursuant to Sections
 36 1343 and 1341 of PPACA, subject only to the adjustments
 37 permitted under paragraph (3).

38 (3) A health care service plan may vary premiums rates for a
 39 particular health benefit plan from its index rate based only on the
 40 following actuarially justified plan-specific factors:

1 (A) The actuarial value and cost-sharing design of the health
2 benefit plan.

3 (B) The health benefit plan’s provider network, delivery system
4 characteristics, and utilization management practices.

5 (C) The benefits provided under the health benefit plan that are
6 in addition to the essential health benefits, as defined pursuant to
7 Section 1302 of PPACA. These additional benefits shall be pooled
8 with similar benefits within the single risk pool required under
9 paragraph (1) and the claims experience from those benefits shall
10 be utilized to determine rate variations for plans that offer those
11 benefits in addition to essential health benefits.

12 (D) With respect to catastrophic plans, as described in subsection
13 (e) of Section 1302 of PPACA, the expected impact of the specific
14 eligibility categories for those plans.

15 (i) This section shall only apply with respect to individual health
16 benefit plans for policy years on or after January 1, 2014.

17 (j) This section shall not apply to an individual health benefit
18 plan that is a grandfathered health plan.

19 1399.851. (a) No health care service plan or solicitor shall,
20 directly or indirectly, engage in the following activities:

21 (1) Encourage or direct an individual to refrain from filing an
22 application for individual coverage with a plan because of the
23 health status, claims experience, industry, occupation, or
24 geographic location, provided that the location is within the plan’s
25 approved service area, of the individual.

26 (2) Encourage or direct an individual to seek individual coverage
27 from another plan or health insurer or the California Health Benefit
28 Exchange because of the health status, claims experience, industry,
29 occupation, or geographic location, provided that the location is
30 within the plan’s approved service area, of the individual.

31 (3) Employ marketing practices or benefit designs that will have
32 the effect of discouraging the enrollment of individuals with
33 significant health needs.

34 (b) A health care service plan shall not, directly or indirectly,
35 enter into any contract, agreement, or arrangement with a solicitor
36 that provides for or results in the compensation paid to a solicitor
37 for the sale of an individual health benefit plan to be varied because
38 of the health status, claims experience, industry, occupation, or
39 geographic location of the individual. This subdivision does not
40 apply to a compensation arrangement that provides compensation

1 to a solicitor on the basis of percentage of premium, provided that
2 the percentage shall not vary because of the health status, claims
3 experience, industry, occupation, or geographic area of the
4 individual.

5 (c) This section shall only apply with respect to individual health
6 benefit plans for policy years on or after January 1, 2014.

7 1399.853. (a) All individual health benefit plans shall conform
8 to the requirements of Sections 1365, 1366.3, 1367.001, and
9 1373.6, and any other requirements imposed by this chapter, and
10 shall be renewable at the option of the enrollee except as permitted
11 to be canceled, rescinded, or not renewed pursuant to Section 1365.

12 (b) Any plan that ceases to offer for sale new individual health
13 benefit plans pursuant to Section 1365 shall continue to be
14 governed by this article with respect to business conducted under
15 this article.

16 1399.855. (a) With respect to individual health benefit plans
17 for policy years on or after January 1, 2014, a health care service
18 plan may use only the following characteristics of an individual,
19 and any dependent thereof, for purposes of establishing the rate
20 of the individual health benefit plan covering the individual and
21 the eligible dependents thereof, along with the health benefit plan
22 selected by the individual:

23 (1) Age, pursuant to the age bands established by the United
24 States Secretary of Health and Human Services and the age rating
25 curve established by the federal Centers for Medicare and Medicaid
26 Services pursuant to Section 2701(a)(3) of the federal Public Health
27 Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall
28 be determined using the individual's age as of the date of the plan
29 issuance or renewal, as applicable, and shall not vary by more than
30 three to one for like individuals of different age who are age 21 or
31 older as described in federal regulations adopted pursuant to
32 Section 2701(a)(3) of the federal Public Health Service Act (42
33 U.S.C. Sec. 300gg(a)(3)).

34 (2) (A) Geographic region. Except as provided in subparagraph
35 (B), the geographic regions for purposes of rating shall be the
36 following:

37 (i) Region 1 shall consist of the Counties of Alpine, Amador,
38 Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt,
39 Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey,

1 Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou,
2 Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

3 (ii) Region 2 shall consist of the Counties of Fresno, Imperial,
4 Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin,
5 San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

6 (iii) Region 3 shall consist of the Counties of Alameda, Contra
7 Costa, Marin, San Francisco, San Mateo, and Santa Clara.

8 (iv) Region 4 shall consist of the Counties of Orange, Santa
9 Barbara, and Ventura.

10 (v) Region 5 shall consist of the County of Los Angeles.

11 (vi) Region 6 shall consist of the Counties of Riverside, San
12 Bernardino, and San Diego.

13 (B) For the 2015 plan year and plan years thereafter, the
14 geographic regions for purposes of rating shall be the following,
15 subject to federal approval if required pursuant to Section 2701 of
16 the federal Public Health Service Act (42 U.S.C. Sec. 300gg) and
17 obtained by the department and the Department of Insurance by
18 July 1, 2014:

19 (i) Region 1 shall consist of the Counties of Alpine, Amador,
20 Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake,
21 Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra,
22 Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

23 (ii) Region 2 shall consist of the Counties of Marin, Napa,
24 Solano, and Sonoma.

25 (iii) Region 3 shall consist of the Counties of El Dorado, Placer,
26 Sacramento, and Yolo.

27 (iv) Region 4 shall consist of the Counties of Alameda, Contra
28 Costa, San Francisco, San Mateo, and Santa Clara.

29 (v) Region 5 shall consist of the Counties of Monterey, San
30 Benito, and Santa Cruz.

31 (vi) Region 6 shall consist of the Counties of Fresno, Kings,
32 Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.

33 (vii) Region 7 shall consist of the Counties of San Luis Obispo,
34 Santa Barbara, and Ventura.

35 (viii) Region 8 shall consist of the Counties of Imperial, Inyo,
36 Kern, and Mono.

37 (ix) Region 9 shall consist of the ZIP Codes in Los Angeles
38 County starting with 906 to 912, inclusive, 915, 917, 918, and 935.

39 (x) Region 10 shall consist of the ZIP Codes in Los Angeles
40 County other than those identified in clause (ix).

1 (xi) Region 11 shall consist of the Counties of Riverside and
2 San Bernardino.

3 (xii) Region 12 shall consist of the County of Orange.

4 (xiii) Region 13 shall consist of the County of San Diego.

5 (C) No later than June 1, 2017, the department, in collaboration
6 with the Exchange and the Department of Insurance, shall review
7 the geographic rating regions specified in this paragraph and the
8 impacts of those regions on the health care coverage market in
9 California, and make a report to the appropriate policy committees
10 of the Legislature.

11 (3) Whether the plan covers an individual or family, as described
12 in PPACA.

13 (b) The rate for a health benefit plan subject to this section shall
14 not vary by any factor not described in this section.

15 (c) With respect to family coverage under an individual health
16 benefit plan, the rating variation permitted under paragraph (1) of
17 subdivision (a) shall be applied based on the portion of the
18 premium attributable to each family member covered under the
19 plan. The total premium for family coverage shall be determined
20 by summing the premiums for each individual family member. In
21 determining the total premium for family members, premiums for
22 no more than the three oldest family members who are under age
23 21 shall be taken into account.

24 (d) The rating period for rates subject to this section shall be
25 from January 1 to December 31, inclusive.

26 (e) This section shall not apply to an individual health benefit
27 plan that is a grandfathered health plan.

28 (f) The requirement for submitting a report imposed under
29 subparagraph (B) of paragraph (2) of subdivision (a) is inoperative
30 on June 1, 2021, pursuant to Section 10231.5 of the Government
31 Code.

32 1399.857. (a) A health care service plan shall not be required
33 to offer an individual health benefit plan or accept applications for
34 the plan pursuant to Section 1399.849 in the case of any of the
35 following:

36 (1) To an individual who does not live or reside within the plan's
37 approved service areas.

38 (2) (A) Within a specific service area or portion of a service
39 area, if the plan reasonably anticipates and demonstrates to the
40 satisfaction of the director both of the following:

1 (i) It will not have sufficient health care delivery resources to
2 ensure that health care services will be available and accessible to
3 the individual because of its obligations to existing enrollees.

4 (ii) It is applying this subparagraph uniformly to all individuals
5 without regard to the claims experience of those individuals or any
6 health status-related factor relating to those individuals.

7 (B) A health care service plan that cannot offer an individual
8 health benefit plan to individuals because it is lacking in sufficient
9 health care delivery resources within a service area or a portion of
10 a service area pursuant to subparagraph (A) shall not offer a health
11 benefit plan in that area to individuals until the later of the
12 following dates:

13 (i) The 181st day after the date coverage is denied pursuant to
14 this paragraph.

15 (ii) The date the plan notifies the director that it has the ability
16 to deliver services to individuals, and certifies to the director that
17 from the date of the notice it will enroll all individuals requesting
18 coverage in that area from the plan.

19 (C) Subparagraph (B) shall not limit the plan's ability to renew
20 coverage already in force or relieve the plan of the responsibility
21 to renew that coverage as described in Section 1365.

22 (D) Coverage offered within a service area after the period
23 specified in subparagraph (B) shall be subject to this section.

24 (b) (1) A health care service plan may decline to offer an
25 individual health benefit plan to an individual if the plan
26 demonstrates to the satisfaction of the director both of the
27 following:

28 (A) It does not have the financial reserves necessary to
29 underwrite additional coverage. In determining whether this
30 subparagraph has been satisfied, the director shall consider, but
31 not be limited to, the plan's compliance with the requirements of
32 Section 1367, Article 6 (commencing with Section 1375), and the
33 rules adopted thereunder.

34 (B) It is applying this subdivision uniformly to all individuals
35 without regard to the claims experience of those individuals any
36 health status-related factor relating to those individuals.

37 (2) A plan that denies coverage to an individual under paragraph
38 (1) shall not offer coverage in the individual market before the
39 later of the following dates:

1 (A) The 181st day after the date that coverage is denied pursuant
2 to paragraph (1).

3 (B) The date the plan demonstrates to the satisfaction of the
4 director that the plan has sufficient financial reserves necessary to
5 underwrite additional coverage.

6 (3) Paragraph (2) shall not limit the plan’s ability to renew
7 coverage already in force or relieve the plan of the responsibility
8 to renew that coverage as described in Section 1365.

9 (4) Coverage offered within a service area after the period
10 specified in paragraph (2) shall be subject to this section.

11 (c) Nothing in this article shall be construed to limit the
12 director’s authority to develop and implement a plan of
13 rehabilitation for a health care service plan whose financial viability
14 or organizational and administrative capacity has become impaired
15 to the extent permitted by PPACA.

16 (d) This section shall not apply to an individual health benefit
17 plan that is a grandfathered health plan.

18 1399.859. (a) A health care service plan that receives an
19 application for an individual health benefit plan outside the
20 Exchange during the initial open enrollment period, an annual
21 enrollment period, or a special enrollment period described in
22 Section 1399.849 shall inform the applicant that he or she may be
23 eligible for lower cost coverage through the Exchange and shall
24 inform the applicant of the applicable enrollment period provided
25 through the Exchange described in Section 1399.849.

26 (b) On or before October 1, 2013, and annually thereafter, a
27 health care service plan shall issue a notice to a subscriber enrolled
28 in an individual health benefit plan offered outside the Exchange.
29 The notice shall inform the subscriber that he or she may be eligible
30 for lower cost coverage through the Exchange and shall inform
31 the subscriber of the applicable open enrollment period provided
32 through the Exchange described in Section 1399.849.

33 (c) This section shall not apply where the individual health
34 benefit plan described in subdivision (a) or (b) is a grandfathered
35 health plan.

36 1399.861. (a) On or before October 1, 2013, and annually
37 thereafter, a health care service plan shall issue the following notice
38 to all subscribers enrolled in an individual health benefit plan that
39 is a grandfathered health plan:
40

1 New improved health insurance options are available in
2 California. You currently have health insurance that is exempt
3 from many of the new requirements. For instance, your plan may
4 not include certain consumer protections that apply to other plans,
5 such as the requirement for the provision of preventive health
6 services without any cost sharing and the prohibition against
7 increasing your rates based on your health status. You have the
8 option to remain in your current plan or switch to a new plan.
9 Under the new rules, a health plan cannot deny your application
10 based on any health conditions you may have. For more
11 information about your options, please contact the California
12 Health Benefit Exchange, the Office of Patient Advocate, your
13 plan representative, an insurance broker, or a health care navigator.
14

15 (b) Commencing October 1, 2013, a health care service plan
16 shall include the notice described in subdivision (a) in any renewal
17 material of the individual grandfathered health plan and in any
18 application for dependent coverage under the individual
19 grandfathered health plan.

20 (c) A health care service plan shall not advertise or market an
21 individual health benefit plan that is a grandfathered health plan
22 for purposes of enrolling a dependent of a subscriber into the plan
23 for policy years on or after January 1, 2014. Nothing in this
24 subdivision shall be construed to prohibit an individual enrolled
25 in an individual grandfathered health plan from adding a dependent
26 to that plan to the extent permitted by PPACA.

27 1399.862. Except as otherwise provided in this article, this
28 article shall only be implemented to the extent that it meets or
29 exceeds the requirements set forth in PPACA.

30 SEC. 23. Section 10113.95 of the Insurance Code is amended
31 to read:

32 10113.95. (a) A health insurer that issues, renews, or amends
33 individual health insurance policies shall be subject to this section.

34 (b) An insurer subject to this section shall have written policies,
35 procedures, or underwriting guidelines establishing the criteria
36 and process whereby the insurer makes its decision to provide or
37 to deny coverage to individuals applying for coverage and sets the
38 rate for that coverage. These guidelines, policies, or procedures
39 shall ensure that the plan rating and underwriting criteria comply

1 with Sections 10140 and 10291.5 and all other applicable
2 provisions.

3 (c) On or before June 1, 2006, and annually thereafter, every
4 insurer shall file with the commissioner a general description of
5 the criteria, policies, procedures, or guidelines that the insurer uses
6 for rating and underwriting decisions related to individual health
7 insurance policies, which means automatic declinable health
8 conditions, health conditions that may lead to a coverage decline,
9 height and weight standards, health history, health care utilization,
10 lifestyle, or behavior that might result in a decline for coverage or
11 severely limit the health insurance products for which individuals
12 applying for coverage would be eligible. An insurer may comply
13 with this section by submitting to the department underwriting
14 materials or resource guides provided to agents and brokers,
15 provided that those materials include the information required to
16 be submitted by this section.

17 (d) Commencing January 1, 2011, the commissioner shall post
18 on the department's Internet Web site, in a manner accessible and
19 understandable to consumers, general, noncompany specific
20 information about rating and underwriting criteria and practices
21 in the individual market and information about the California Major
22 Risk Medical Insurance Program (Part 6.5 (commencing with
23 Section 12700)) and the federal temporary high risk pool
24 established pursuant to Part 6.6 (commencing with Section
25 12739.5). The commissioner shall develop the information for the
26 Internet Web site in consultation with the Department of Managed
27 Health Care to enhance the consistency of information provided
28 to consumers. Information about individual health insurance shall
29 also include the following notification:
30

31 "Please examine your options carefully before declining group
32 coverage or continuation coverage, such as COBRA, that may be
33 available to you. You should be aware that companies selling
34 individual health insurance typically require a review of your
35 medical history that could result in a higher premium or you could
36 be denied coverage entirely."
37

38 (e) Nothing in this section shall authorize public disclosure of
39 company-specific rating and underwriting criteria and practices
40 submitted to the commissioner.

1 (f) This section shall not apply to a closed block of business, as
2 defined in Section 10176.10.

3 (g) *This section shall become inoperative on November 1, 2013,*
4 *or the 91st calendar day following the adjournment of the 2013–14*
5 *First Extraordinary Session, whichever date is later.*

6 SEC. 24. Section 10113.95 is added to the Insurance Code, to
7 read:

8 10113.95. (a) A health insurer that renews individual
9 grandfathered health plans shall be subject to this section.

10 (b) An insurer subject to this section shall have written policies,
11 procedures, or underwriting guidelines establishing the criteria
12 and process whereby the insurer makes its decision to provide or
13 to deny coverage to individuals applying for an individual
14 grandfathered health plan and sets the rate for that coverage. These
15 guidelines, policies, or procedures shall ensure that the plan rating
16 and underwriting criteria comply with Sections 10140 and 10291.5
17 and all other applicable provisions.

18 (c) On or before the June 1 next following the operative date of
19 this section, and annually thereafter, every insurer shall file with
20 the commissioner a general description of the criteria, policies,
21 procedures, or guidelines that the insurer uses for rating and
22 underwriting decisions related to individual grandfathered health
23 plans, which means automatic declinable health conditions, health
24 conditions that may lead to a coverage decline, height and weight
25 standards, health history, health care utilization, lifestyle, or
26 behavior that might result in a decline for coverage or severely
27 limit the health insurance products for which individuals applying
28 for coverage would be eligible. An insurer may comply with this
29 section by submitting to the department underwriting materials or
30 resource guides provided to agents and brokers, provided that those
31 materials include the information required to be submitted by this
32 section.

33 (d) Nothing in this section shall authorize public disclosure of
34 company-specific rating and underwriting criteria and practices
35 submitted to the commissioner.

36 (e) This section shall not apply to a closed block of business,
37 as defined in Section 10176.10.

38 (f) For purposes of this section, the following definitions shall
39 apply:

1 (1) “PPACA” means the federal Patient Protection and
2 Affordable Care Act (Public Law 111-148), as amended by the
3 federal Health Care and Education Reconciliation Act of 2010
4 (Public Law 111-152), and any rules, regulations, or guidance
5 issued pursuant to that law.

6 (2) “Grandfathered health plan” has the same meaning as that
7 term is defined in Section 1251 of PPACA.

8 (g) This section shall become operative on November 1, 2013,
9 or the 91st calendar day following the adjournment of the 2013–14
10 First Extraordinary Session, whichever date is later.

11 SEC. 25. Section 10119.1 of the Insurance Code is amended
12 to read:

13 10119.1. (a) This section shall apply to a health insurer that
14 covers hospital, medical, or surgical expenses under an individual
15 health benefit plan, as defined in subdivision (a) of Section
16 10198.6, that is issued, amended, renewed, or delivered on or after
17 January 1, 2007.

18 (b) At least once each year, a health insurer shall permit an
19 individual who has been covered for at least 18 months under an
20 individual health benefit plan to transfer, without medical
21 underwriting, to any other individual health benefit plan offered
22 by that same health insurer that provides equal or lesser benefits
23 as determined by the insurer.

24 “Without medical underwriting” means that the health insurer
25 shall not decline to offer coverage to, or deny enrollment of, the
26 individual or impose any preexisting condition exclusion on the
27 individual who transfers to another individual health benefit plan
28 pursuant to this section.

29 (c) The insurer shall establish, for the purposes of subdivision
30 (b), a ranking of the individual health benefit plans it offers to
31 individual purchasers and post the ranking on its Internet Web site
32 or make the ranking available upon request. The insurer shall
33 update the ranking whenever a new benefit design for individual
34 purchasers is approved.

35 (d) The insurer shall notify in writing all insureds of the right
36 to transfer to another individual health benefit plan pursuant to
37 this section, at a minimum, when the insurer changes the insured’s
38 premium rate. Posting this information on the insurer’s Internet
39 Web site shall not constitute notice for purposes of this subdivision.
40 The notice shall adequately inform insureds of the transfer rights

1 provided under this section including information on the process
2 to obtain details about the individual health benefit plans available
3 to that insured and advising that the insured may be unable to
4 return to his or her current individual health benefit plan if the
5 insured transfers to another individual health benefit plan.

6 (e) The requirements of this section shall not apply to the
7 following:

8 (1) A federally eligible defined individual, as defined in
9 subdivision (e) of Section 10900, who purchases individual
10 coverage pursuant to Section 10785.

11 (2) An individual offered conversion coverage pursuant to
12 Sections 12672 and 12682.1.

13 (3) An individual enrolled in the Medi-Cal program pursuant
14 to Chapter 7 (commencing with Section 14000) of Part 3 of
15 Division 9 of the Welfare and Institutions Code.

16 (4) An individual enrolled in the Access for Infants and Mothers
17 Program, pursuant to Part 6.3 (commencing with Section 12695).

18 (5) An individual enrolled in the Healthy Families Program
19 pursuant to Part 6.2 (commencing with Section 12693).

20 (f) It is the intent of the Legislature that individuals shall have
21 more choice in their health care coverage when health insurers
22 guarantee the right of an individual to transfer to another product
23 based on the insurer's own ranking system. The Legislature does
24 not intend for the department to review or verify the insurer's
25 ranking for actuarial or other purposes.

26 (g) *This section shall remain in effect only until January 1, 2014,*
27 *or the 91st calendar day following the adjournment of the 2013–14*
28 *First Extraordinary Session, whichever date is later, and as of*
29 *that date is repealed, unless a later enacted statute, that becomes*
30 *operative on or before that date, deletes or extends the date on*
31 *which it is repealed.*

32 SEC. 26. Section 10119.2 of the Insurance Code is amended
33 to read:

34 10119.2. (a) Every health insurer that offers, issues, or renews
35 health insurance under an individual health benefit plan, as defined
36 in subdivision (a) of Section 10198.6, shall offer to any individual,
37 who was covered under an individual health benefit plan that was
38 rescinded, a new individual health benefit plan without medical
39 underwriting that provides equal benefits. A health insurer may
40 also permit an individual, who was covered under an individual

1 health benefit plan that was rescinded, to remain covered under
2 that individual health benefit plan, with a revised premium rate
3 that reflects the number of persons remaining on the health benefit
4 plan.

5 (b) “Without medical underwriting” means that the health insurer
6 shall not decline to offer coverage to, or deny enrollment of, the
7 individual or impose any preexisting condition exclusion on the
8 individual who is issued a new individual health benefit plan or
9 remains covered under an individual health benefit plan pursuant
10 to this section.

11 (c) If a new individual health benefit plan is issued, the insurer
12 may revise the premium rate to reflect only the number of persons
13 covered under the new individual health benefit plan.

14 (d) Notwithstanding subdivision (a) and (b), if an individual
15 was subject to a preexisting condition provision or a waiting or
16 affiliation period under the individual health benefit plan that was
17 rescinded, the health insurer may apply the same preexisting
18 condition provision or waiting or affiliation period in the new
19 individual health benefit plan. The time period in the new
20 individual health benefit plan for the preexisting condition
21 provision or waiting or affiliation period shall not be longer than
22 the one in the individual health benefit plan that was rescinded
23 and the health insurer shall credit any time that the individual was
24 covered under the rescinded individual health benefit plan.

25 (e) The insurer shall notify in writing all insureds of the right
26 to coverage under an individual health benefit plan pursuant to
27 this section, at a minimum, when the insurer rescinds the individual
28 health benefit plan. The notice shall adequately inform insureds
29 of the right to coverage provided under this section.

30 (f) The insurer shall provide 60 days for insureds to accept the
31 offered new individual health benefit plan and this plan shall be
32 effective as of the effective date of the original individual health
33 benefit plan and there shall be no lapse in coverage.

34 (g) This section shall not apply to any individual whose
35 information in the application for coverage and related
36 communications led to the rescission.

37 (h) *This section shall become inoperative on January 1, 2014,*
38 *or the 91st calendar day following the adjournment of the 2013–14*
39 *First Extraordinary Session, whichever date is later.*

1 SEC. 27. Section 10119.2 is added to the Insurance Code, to
2 read:

3 10119.2. (a) Every health insurer that offers, issues, or renews
4 health insurance under an individual health benefit plan, as defined
5 in subdivision (a) of Section 10198.6, through the California Health
6 Benefit Exchange shall offer to any individual, who was covered
7 by the insurer under an individual health benefit plan that was
8 rescinded, a new individual health benefit plan through the
9 Exchange that provides the most equivalent benefits.

10 (b) A health insurer that offers, issues, or renews individual
11 health benefit plans inside or outside the California Health Benefit
12 Exchange may also permit an individual, who was covered by the
13 insurer under an individual health benefit plan that was rescinded,
14 to remain covered under that individual health benefit plan, with
15 a revised premium rate that reflects the number of persons
16 remaining on the health benefit plan consistent with Section
17 10965.9.

18 (c) If a new individual health benefit plan is issued under
19 subdivision (a), the insurer may revise the premium rate to reflect
20 only the number of persons covered on the new individual health
21 benefit plan consistent with Section 10965.9.

22 (d) The insurer shall notify in writing all insureds of the right
23 to coverage under an individual health benefit plan pursuant to
24 this section, at a minimum, when the insurer rescinds the individual
25 health benefit plan. The notice shall adequately inform insureds
26 of the right to coverage provided under this section.

27 (e) The insurer shall provide 60 days for insureds to accept the
28 offered new individual health benefit plan under subdivision (a),
29 and this plan shall be effective as of the effective date of the
30 original health benefit plan and there shall be no lapse in coverage.

31 (f) This section shall not apply to any individual whose
32 information in the application for coverage and related
33 communications led to the rescission.

34 (g) This section shall apply notwithstanding subdivision (a) or
35 (d) of Section 10965.3.

36 (h) This section shall become operative on January 1, 2014, or
37 the 91st calendar day following the adjournment of the 2013–14
38 First Extraordinary Session, whichever date is later.

39 SEC. 28. Section 10127.21 is added to the Insurance Code, to
40 read:

1 10127.21. Any data submitted by a health insurer to the United
 2 States Secretary of Health and Human Services, or his or her
 3 designee, for purposes of the risk adjustment program described
 4 in Section 1343 of the federal Patient Protection and Affordable
 5 Care Act (42 U.S.C. Sec. 18063) shall be concurrently submitted
 6 to the department.

7 SEC. 29. Section 10198.7 of the Insurance Code is amended
 8 to read:

9 ~~10198.7. (a) A nongrandfathered health benefit plan for group~~
 10 ~~or individual coverage or a grandfathered health benefit plan for~~
 11 group coverage shall not impose any preexisting condition
 12 provision or waived condition provision upon any individual.

13 (b) *A nongrandfathered health benefit plan for individual*
 14 *coverage shall not impose any preexisting condition provision or*
 15 *waived condition provision upon any individual.* A grandfathered
 16 health benefit plan for individual coverage shall not exclude
 17 coverage on the basis of a waived condition provision or
 18 preexisting condition provision for a period greater than 12 months
 19 following the individual’s effective date of coverage, nor limit or
 20 exclude coverage for a specific insured by type of illness, treatment,
 21 medical condition, or accident, except for satisfaction of a
 22 preexisting condition ~~clause~~ *provision* or waived condition
 23 provision pursuant to this article. Waivered condition provisions
 24 or preexisting condition provisions contained in health benefit
 25 plans may relate only to conditions for which medical advice,
 26 diagnosis, care, or treatment, including use of prescription drugs,
 27 was recommended or received from a licensed health practitioner
 28 during the 12 months immediately preceding the effective date of
 29 coverage.

30 (c) (1) A health benefit plan for group coverage may apply a
 31 waiting period of up to 60 days as a condition of employment if
 32 applied equally to all eligible employees and dependents and if
 33 consistent with PPACA. ~~A waiting period~~ *waiting period* shall not
 34 be based on a preexisting condition of an employee or dependent,
 35 the health status of an employee or dependent, or any other factor
 36 listed in Section 10198.9. During the waiting period, the health
 37 benefit plan is not required to provide health care services and no
 38 premium shall be charged to the policyholder or insureds.

39 (2) A health benefit plan for individual coverage shall not
 40 impose a waiting period.

1 (d) In determining whether a preexisting condition provision,
2 a waived condition provision, or a waiting period applies to a
3 person, a health benefit plan shall credit the time the person was
4 covered under creditable coverage, provided that the person
5 becomes eligible for coverage under the succeeding health benefit
6 plan within 62 days of termination of prior coverage, exclusive of
7 any waiting period, and applies for coverage under the succeeding
8 plan within the applicable enrollment period. A plan shall also
9 credit any time that an eligible employee must wait before enrolling
10 in the plan, including any postenrollment or employer-imposed
11 waiting period. However, if a person's employment has ended, the
12 availability of health coverage offered through employment or
13 sponsored by an employer has terminated, or an employer's
14 contribution toward health coverage has terminated, a carrier shall
15 credit the time the person was covered under creditable coverage
16 if the person becomes eligible for health coverage offered through
17 employment or sponsored by an employer within 180 days,
18 exclusive of any waiting period, and applies for coverage under
19 the succeeding plan within the applicable enrollment period.

20 (e) An individual's period of creditable coverage shall be
21 certified pursuant to Section 2704(e) of Title XXVII of the federal
22 Public Health Service Act (42 U.S.C. Sec. 300gg-3(e)).

23 SEC. 30. Section 10753.05 of the Insurance Code is amended
24 to read:

25 10753.05. (a) No group or individual policy or contract or
26 certificate of group insurance or statement of group coverage
27 providing benefits to employees of small employers as defined in
28 this chapter shall be issued or delivered by a carrier subject to the
29 jurisdiction of the commissioner regardless of the situs of the
30 contract or master policyholder or of the domicile of the carrier
31 nor, except as otherwise provided in Sections 10270.91 and
32 10270.92, shall a carrier provide coverage subject to this chapter
33 until a copy of the form of the policy, contract, certificate, or
34 statement of coverage is filed with and approved by the
35 commissioner in accordance with Sections 10290 and 10291, and
36 the carrier has complied with the requirements of Section 10753.17.

37 (b) (1) On and after October 1, 2013, each carrier shall fairly
38 and affirmatively offer, market, and sell all of the carrier's health
39 benefit plans that are sold to, offered through, or sponsored by,
40 small employers or associations that include small employers for

1 plan years on or after January 1, 2014, to all small employers in
2 each geographic region in which the carrier makes coverage
3 available or provides benefits.

4 (2) A carrier that offers qualified health plans through the
5 Exchange shall be deemed to be in compliance with paragraph (1)
6 with respect to health benefit plans offered through the Exchange
7 in those geographic regions in which the carrier offers plans
8 through the Exchange.

9 (3) A carrier shall provide enrollment periods consistent with
10 PPACA and ~~set forth~~ *described* in Section 155.725 of Title 45 of
11 the Code of Federal Regulations. ~~A Commencing January 1, 2014,~~
12 *a* carrier shall provide special enrollment periods consistent with
13 the special enrollment periods ~~required in the individual~~
14 ~~nongrandfathered market in the state, as set forth~~ *described* in
15 Section 10965.3, except for the triggering events identified in
16 paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of the
17 Code of Federal Regulations with respect to health benefit plans
18 offered through the Exchange.

19 (4) Nothing in this section shall be construed to require an
20 association, or a trust established and maintained by an association
21 to receive a master insurance policy issued by an admitted insurer
22 and to administer the benefits thereof solely for association
23 members, to offer, market or sell a benefit plan design to those
24 who are not members of the association. However, if the
25 association markets, offers or sells a benefit plan design to those
26 who are not members of the association it is subject to the
27 requirements of this section. This shall apply to an association that
28 otherwise meets the requirements of paragraph (8) formed by
29 merger of two or more associations after January 1, 1992, if the
30 predecessor organizations had been in active existence on January
31 1, 1992, and for at least five years prior to that date and met the
32 requirements of paragraph (5).

33 (5) A carrier which (A) effective January 1, 1992, and at least
34 20 years prior to that date, markets, offers, or sells benefit plan
35 designs only to all members of one association and (B) does not
36 market, offer or sell any other individual, selected group, or group
37 policy or contract providing medical, hospital and surgical benefits
38 shall not be required to market, offer, or sell to those who are not
39 members of the association. However, if the carrier markets, offers
40 or sells any benefit plan design or any other individual, selected

1 group, or group policy or contract providing medical, hospital and
2 surgical benefits to those who are not members of the association
3 it is subject to the requirements of this section.

4 (6) Each carrier that sells health benefit plans to members of
5 one association pursuant to paragraph (5) shall submit an annual
6 statement to the commissioner which states that the carrier is selling
7 health benefit plans pursuant to paragraph (5) and which, for the
8 one association, lists all the information required by paragraph (7).

9 (7) Each carrier that sells health benefit plans to members of
10 any association shall submit an annual statement to the
11 commissioner which lists each association to which the carrier
12 sells health benefit plans, the industry or profession which is served
13 by the association, the association's membership criteria, a list of
14 officers, the state in which the association is organized, and the
15 site of its principal office.

16 (8) For purposes of paragraphs (4) and (6), an association is a
17 nonprofit organization comprised of a group of individuals or
18 employers who associate based solely on participation in a
19 specified profession or industry, accepting for membership any
20 individual or small employer meeting its membership criteria,
21 which do not condition membership directly or indirectly on the
22 health or claims history of any person, which uses membership
23 dues solely for and in consideration of the membership and
24 membership benefits, except that the amount of the dues shall not
25 depend on whether the member applies for or purchases insurance
26 offered by the association, which is organized and maintained in
27 good faith for purposes unrelated to insurance, which has been in
28 active existence on January 1, 1992, and at least five years prior
29 to that date, which has a constitution and bylaws, or other
30 analogous governing documents which provide for election of the
31 governing board of the association by its members, which has
32 contracted with one or more carriers to offer one or more health
33 benefit plans to all individual members and small employer
34 members in this state.

35 (c) On and after October 1, 2013, each carrier shall make
36 available to each small employer all health benefit plans that the
37 carrier offers or sells to small employers or to associations that
38 include small employers for plan years on or after January 1, 2014.
39 Notwithstanding subdivision (d) of Section 10753, for purposes
40 of this subdivision, companies that are affiliated companies or that

1 are eligible to file a consolidated income tax return shall be treated
2 as one carrier.

3 (d) Each carrier shall do all of the following:

4 (1) Prepare a brochure that summarizes all of its health benefit
5 plans and make this summary available to small employers, agents,
6 and brokers upon request. The summary shall include for each
7 plan information on benefits provided, a generic description of the
8 manner in which services are provided, such as how access to
9 providers is limited, benefit limitations, required copayments and
10 deductibles, an explanation of how creditable coverage is calculated
11 if a waiting period is imposed, and a telephone number that can
12 be called for more detailed benefit information. Carriers are
13 required to keep the information contained in the brochure accurate
14 and up to date, and, upon updating the brochure, send copies to
15 agents and brokers representing the carrier. Any entity that provides
16 administrative services only with regard to a health benefit plan
17 written or issued by another carrier shall not be required to prepare
18 a summary brochure which includes that benefit plan.

19 (2) For each health benefit plan, prepare a more detailed
20 evidence of coverage and make it available to small employers,
21 agents and brokers upon request. The evidence of coverage shall
22 contain all information that a prudent buyer would need to be aware
23 of in making selections of benefit plan designs. An entity that
24 provides administrative services only with regard to a health benefit
25 plan written or issued by another carrier shall not be required to
26 prepare an evidence of coverage for that health benefit plan.

27 (3) Provide copies of the current summary brochure to all agents
28 or brokers who represent the carrier and, upon updating the
29 brochure, send copies of the updated brochure to agents and brokers
30 representing the carrier for the purpose of selling health benefit
31 plans.

32 (4) Notwithstanding subdivision (c) of Section 10753, for
33 purposes of this subdivision, companies that are affiliated
34 companies or that are eligible to file a consolidated income tax
35 return shall be treated as one carrier.

36 (e) Every agent or broker representing one or more carriers for
37 the purpose of selling health benefit plans to small employers shall
38 do all of the following:

1 (1) When providing information on a health benefit plan to a
2 small employer but making no specific recommendations on
3 particular benefit plan designs:

4 (A) Advise the small employer of the carrier's obligation to sell
5 to any small employer any of the health benefit plans it offers to
6 small employers, consistent with PPACA, and provide them, upon
7 request, with the actual rates that would be charged to that
8 employer for a given health benefit plan.

9 (B) Notify the small employer that the agent or broker will
10 procure rate and benefit information for the small employer on
11 any health benefit plan offered by a carrier for whom the agent or
12 broker sells health benefit plans.

13 (C) Notify the small employer that, upon request, the agent or
14 broker will provide the small employer with the summary brochure
15 required in paragraph (1) of subdivision (d) for any benefit plan
16 design offered by a carrier whom the agent or broker represents.

17 (D) Notify the small employer of the availability of coverage
18 and the availability of tax credits for certain employers consistent
19 with PPACA and state law, including any rules, regulations, or
20 guidance issued in connection therewith.

21 (2) When recommending a particular benefit plan design or
22 designs, advise the small employer that, upon request, the agent
23 will provide the small employer with the brochure required by
24 paragraph (1) of subdivision (d) containing the benefit plan design
25 or designs being recommended by the agent or broker.

26 (3) Prior to filing an application for a small employer for a
27 particular health benefit plan:

28 (A) For each of the health benefit plans offered by the carrier
29 whose health benefit plan the agent or broker is presenting, provide
30 the small employer with the benefit summary required in paragraph
31 (1) of subdivision (d) and the premium for that particular employer.

32 (B) Notify the small employer that, upon request, the agent or
33 broker will provide the small employer with an evidence of
34 coverage brochure for each health benefit plan the carrier offers.

35 (C) Obtain a signed statement from the small employer
36 acknowledging that the small employer has received the disclosures
37 required by this paragraph and Section 10753.16.

38 (f) No carrier, agent, or broker shall induce or otherwise
39 encourage a small employer to separate or otherwise exclude an
40 eligible employee from a health benefit plan which, in the case of

1 an eligible employee meeting the definition in paragraph (1) of
2 subdivision (f) of Section 10753, is provided in connection with
3 the employee's employment or which, in the case of an eligible
4 employee as defined in paragraph (2) of subdivision (f) of Section
5 10753, is provided in connection with a guaranteed association.

6 (g) No carrier shall reject an application from a small employer
7 for a health benefit plan provided:

8 (1) The small employer as defined by subparagraph (A) of
9 paragraph (1) of subdivision (q) of Section 10753 offers health
10 benefits to 100 percent of its eligible employees as defined in
11 paragraph (1) of subdivision (f) of Section 10753. Employees who
12 waive coverage on the grounds that they have other group coverage
13 shall not be counted as eligible employees.

14 (2) The small employer agrees to make the required premium
15 payments.

16 (h) No carrier or agent or broker shall, directly or indirectly,
17 engage in the following activities:

18 (1) Encourage or direct small employers to refrain from filing
19 an application for coverage with a carrier because of the health
20 status, claims experience, industry, occupation, or geographic
21 location within the carrier's approved service area of the small
22 employer or the small employer's employees.

23 (2) Encourage or direct small employers to seek coverage from
24 another carrier because of the health status, claims experience,
25 industry, occupation, or geographic location within the carrier's
26 approved service area of the small employer or the small
27 employer's employees.

28 (3) *Employ marketing practices or benefit designs that will have*
29 *the effect of discouraging the enrollment of individuals with*
30 *significant health needs.*

31 (i) No carrier shall, directly or indirectly, enter into any contract,
32 agreement, or arrangement with an agent or broker that provides
33 for or results in the compensation paid to an agent or broker for a
34 health benefit plan to be varied because of the health status, claims
35 experience, industry, occupation, or geographic location of the
36 small employer or the small employer's employees. This
37 subdivision shall not apply with respect to a compensation
38 arrangement that provides compensation to an agent or broker on
39 the basis of percentage of premium, provided that the percentage

1 shall not vary because of the health status, claims experience,
2 industry, occupation, or geographic area of the small employer.

3 (j) (1) A health benefit plan offered to a small employer, as
4 defined in Section 1304(b) of PPACA and in Section 10753, shall
5 not establish rules for eligibility, including continued eligibility,
6 of an individual, or dependent of an individual, to enroll under the
7 terms of the plan based on any of the following health status-related
8 factors:

9 (A) Health status.

10 (B) Medical condition, including physical and mental illnesses.

11 (C) Claims experience.

12 (D) Receipt of health care.

13 (E) Medical history.

14 (F) Genetic information.

15 (G) Evidence of insurability, including conditions arising out
16 of acts of domestic violence.

17 (H) Disability.

18 (I) Any other health status-related factor as determined by any
19 federal regulations, rules, or guidance issued pursuant to Section
20 2705 of the federal Public Health Service Act.

21 (2) Notwithstanding Section 10291.5, a carrier shall not require
22 an eligible employee or dependent to fill out a health assessment
23 or medical questionnaire prior to enrollment under a health benefit
24 plan. A carrier shall not acquire or request information that relates
25 to a health status-related factor from the applicant or his or her
26 dependent or any other source prior to enrollment of the individual.

27 (k) (1) *A carrier shall consider the claims experience of all*
28 *insureds in all nongrandfathered health benefit plans offered in*
29 *the state that are subject to subdivision (a), including those*
30 *insureds who do not enroll in the plans through the Exchange, to*
31 *be members of a single risk pool.*

32 (2) *Each plan year, a carrier shall establish an index rate for*
33 *the small employer market in the state based on the total combined*
34 *claims costs for providing essential health benefits, as defined*
35 *pursuant to Section 1302 of PPACA, within the single risk pool*
36 *required under paragraph (1). The index rate shall be adjusted*
37 *on a market-wide basis based on the total expected market-wide*
38 *payments and charges under the risk adjustment and reinsurance*
39 *programs established for the state pursuant to Sections 1343 and*
40 *1341 of PPACA. The premium rate for all of the carrier's*

1 *nongrandfathered health benefit plans shall use the applicable*
 2 *index rate, as adjusted for total expected market-wide payments*
 3 *and charges under the risk adjustment and reinsurance programs*
 4 *established for the state pursuant to Sections 1343 and 1341 of*
 5 *PPACA, subject only to the adjustments permitted under paragraph*
 6 *(3).*

7 *(3) A carrier may vary premiums rates for a particular*
 8 *nongrandfathered health benefit plan from its index rate based*
 9 *only on the following actuarially justified plan-specific factors:*

10 *(A) The actuarial value and cost-sharing design of the health*
 11 *benefit plan.*

12 *(B) The health benefit plan’s provider network, delivery system*
 13 *characteristics, and utilization management practices.*

14 *(C) The benefits provided under the health benefit plan that are*
 15 *in addition to the essential health benefits, as defined pursuant to*
 16 *Section 1302 of PPACA. These additional benefits shall be pooled*
 17 *with similar benefits within the single risk pool required under*
 18 *paragraph (1) and the claims experience from those benefits shall*
 19 *be utilized to determine rate variations for health benefit plans*
 20 *that offer those benefits in addition to essential health benefits.*

21 *(D) With respect to catastrophic plans, as described in*
 22 *subsection (e) of Section 1302 of PPACA, the expected impact of*
 23 *the specific eligibility categories for those plans.*

24 ~~(k)~~

25 *(l) If a carrier enters into a contract, agreement, or other*
 26 *arrangement with a third-party administrator or other entity to*
 27 *provide administrative, marketing, or other services related to the*
 28 *offering of health benefit plans to small employers in this state,*
 29 *the third-party administrator shall be subject to this chapter.*

30 ~~*(t) (1) With respect to the obligation to provide coverage newly*~~
 31 ~~*issued under subdivision (c), to the extent permitted by PPACA,*~~
 32 ~~*the carrier may cease enrolling new small employer groups and*~~
 33 ~~*new eligible employees as defined by paragraph (2) of subdivision*~~
 34 ~~*(f) of Section 10753 if it certifies to the commissioner that the*~~
 35 ~~*number of eligible employees and dependents, of the employers*~~
 36 ~~*newly enrolled or insured during the current calendar year by the*~~
 37 ~~*carrier equals or exceeds: (A) in the case of a carrier that*~~
 38 ~~*administers any self-funded health benefits arrangement in*~~
 39 ~~*California, 10 percent of the total number of eligible employees,*~~
 40 ~~*or eligible employees and dependents, respectively, enrolled or*~~

1 insured in California by that carrier as of December 31 of the
2 preceding year, or (B) in the case of a carrier that does not
3 administer any self-funded health benefit arrangements in
4 California, 8 percent of the total number of eligible employees, or
5 eligible employees and dependents, respectively, enrolled or
6 insured by the carrier in California as of December 31 of the
7 preceding year.

8 (2) Certification shall be deemed approved if not disapproved
9 within 45 days after submission to the commissioner. If that
10 certification is approved, the small employer carrier shall not offer
11 coverage to any small employers under any health benefit plans
12 during the remainder of the current year. If the certification is not
13 approved, the carrier shall continue to issue coverage as required
14 by subdivision (c) and be subject to administrative penalties as
15 established in Section 10753.18.

16 (m) (1) Except as provided in paragraph (2), this section shall
17 become inoperative if Section 2702 of the federal Public Health
18 Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201
19 of PPACA, is repealed, in which case carriers subject to this section
20 shall instead be governed by Section 10705 to the extent permitted
21 by federal law, and all references in this chapter to this section
22 shall instead refer to Section 10705, except for purposes of
23 paragraph (2).

24 (2) Paragraph (3) of subdivision (b) of this section shall remain
25 operative as it relates to health benefit plans offered through the
26 Exchange.

27 SEC. 31. Section 10753.06.5 of the Insurance Code is amended
28 to read:

29 10753.06.5. (a) With respect to health benefit plans offered
30 outside the Exchange, after a small employer submits a completed
31 application, the carrier shall, within 30 days, notify the employer
32 of the employer's actual rates in accordance with Section 10753.14.
33 The employer shall have 30 days in which to exercise the right to
34 buy coverage at the quoted rates.

35 (b) (1) Except as required under paragraph (2) subdivision (c),
36 when a small employer submits a premium payment, based on the
37 quoted rates, and that payment is delivered or postmarked,
38 whichever occurs earlier, within the first 15 days of a month,
39 coverage shall become effective no later than the first day of the
40 following month. When that payment is neither delivered nor

1 postmarked until after the 15th day of a month, coverage shall
2 become effective no later than the first day of the second month
3 following delivery or postmark of the payment.

4 ~~(2) A carrier shall apply coverage effective dates for health
5 benefit plans subject to this chapter consistent with the coverage
6 effective dates applicable to nongrandfathered individual health
7 benefit plans set forth in Section 10965.3.~~

8 *(c) (1) With respect to a health benefit plan offered through
9 the Exchange, a carrier shall apply coverage effective dates
10 consistent with those required under Section 155.720 of Title 45
11 of the Code of Federal Regulations and paragraph (2) of
12 subdivision (e) of Section 10965.3.*

13 *(2) With respect to a health benefit plan offered outside the
14 Exchange for which an individual applies during a special
15 enrollment period described in paragraph (3) of subdivision (b)
16 of Section 10753.05, the following provisions shall apply:*

17 *(A) Coverage under the plan shall become effective no later
18 than the first day of the first calendar month beginning after the
19 date the carrier receives the request for special enrollment.*

20 *(B) Notwithstanding subparagraph (A), in the case of a birth,
21 adoption, or placement for adoption, coverage under the plan shall
22 become effective on the date of birth, adoption, or placement for
23 adoption.*

24 ~~(e)~~
25 *(d) During the first 30 days of coverage, the small employer
26 shall have the option of changing coverage to a different health
27 benefit plan offered by the same carrier. If a small employer
28 notifies the carrier of the change within the first 15 days of a month,
29 coverage under the new health benefit plan shall become effective
30 no later than the first day of the following month. If a small
31 employer notifies the carrier of the change after the 15th day of a
32 month, coverage under the new health benefit plan shall become
33 effective no later than the first day of the second month following
34 notification.*

35 ~~(e)~~
36 *(e) All eligible employees and dependents listed on the small
37 employer's completed application shall be covered on the effective
38 date of the health benefit plan.*

39 SEC. 32. Section 10753.11 of the Insurance Code is amended
40 to read:

1 10753.11. (a) To the extent permitted by PPACA, no carrier
2 shall be required by the provisions of this chapter *to do any of the*
3 *following*:

4 ~~(a) To offer coverage to, or accept applications from, a small~~
5 ~~employer as defined in subparagraph (A) of paragraph (1) of~~
6 ~~subdivision (q) of Section 10753, where the small employer is not~~
7 ~~physically located in a carrier’s approved service areas.~~

8 ~~(b)~~
9 ~~(1) To offer coverage to or accept applications from a small~~
10 ~~employer as defined in subparagraph (B) of paragraph (1) of~~
11 ~~subdivision (q) of Section 10753 where the small employer is~~
12 ~~seeking coverage for eligible employees who do not live, work,~~
13 ~~or reside in a carrier’s approved service areas.~~

14 ~~(c) To include in a health benefit plan an otherwise eligible~~
15 ~~employee or dependent, when the eligible employee or dependent~~
16 ~~does not work or reside within a carrier’s approved service area,~~
17 ~~except as provided in Section 10753.02.1.~~

18 ~~(d)~~
19 (2) (A) To offer coverage to, or accept applications from, a
20 small employer for a benefits plan design within an area if the
21 commissioner has found ~~that the carrier will~~ *all of the following*:

22 (i) *The carrier will* not have the capacity within the area in its
23 network of providers to deliver service adequately to the eligible
24 employees and dependents of that employee because of its
25 obligations to existing group contractholders and enrollees ~~and~~
26 ~~that the.~~

27 (ii) *The carrier is applying this paragraph uniformly to all*
28 *employers without regard to the claims experience of those*
29 *employers, and their employees and dependents, or any health*
30 *status-related factor relating to those employees and dependents.*

31 (iii) *The action is not unreasonable or clearly inconsistent with*
32 *the intent of this chapter.*

33 ~~A carrier~~

34 (B) *A carrier* that cannot offer coverage to small employers in
35 a specific service area because it is lacking sufficient capacity *as*
36 *described in this paragraph* may not offer coverage in the
37 applicable area to new employer groups with more than 50 eligible
38 employees until the *later of the following dates*:

39 (i) *The 181st day after the date that coverage is denied pursuant*
40 *to this paragraph.*

1 (ii) *The date the carrier notifies the commissioner that it has*
2 *regained capacity to deliver services to small employers, and*
3 *certifies to the commissioner that from the date of the notice it will*
4 *enroll all small groups requesting coverage from the carrier until*
5 *the carrier has met the requirements of subdivision ~~(h)~~ (g) of*
6 *Section 10753.05.*

7 (C) *Subparagraph (B) shall not limit the carrier's ability to*
8 *renew coverage already in force or relieve the carrier of the*
9 *responsibility to renew that coverage as described in Sections*
10 *10273.4 and 10753.13.*

11 (D) *Coverage offered within a service area after the period*
12 *specified in subparagraph (B) shall be subject to the requirements*
13 *of this section.*

14 ~~(e) To offer coverage to a small employer, or an eligible~~
15 ~~employee as defined in paragraph (2) of subdivision (f) of Section~~
16 ~~10753, who within 12 months of application for coverage~~
17 ~~terminated from a health benefit plan offered by the carrier.~~

18 SEC. 33. Section 10753.12 of the Insurance Code is amended
19 to read:

20 10753.12. (a) A carrier shall not be required to offer coverage
21 or accept applications for benefit plan designs pursuant to this
22 chapter where the ~~commissioner determines that the~~ *carrier*
23 *demonstrates to the satisfaction of the commissioner both of the*
24 *following:*

25 (1) *The acceptance of an application or applications would place*
26 *the carrier in a financially impaired condition.*

27 (2) *The carrier is applying this subdivision uniformly to all*
28 *employers without regard to the claims experience of those*
29 *employers and their employees and dependents or any health*
30 *status-related factor relating to those employees and dependents.*

31 (b) *The commissioner's determination under subdivision (a)*
32 *shall follow an evaluation that includes a certification by the*
33 *commissioner that the acceptance of an application or applications*
34 *would place the carrier in a financially impaired condition.*

35 (c) *A carrier that has not offered coverage or accepted*
36 *applications pursuant to this chapter shall not offer coverage or*
37 *accept applications for any individual or group health benefit plan*
38 *until the ~~commissioner has determined that~~ later of the following*
39 *dates:*

1 (1) *The 181st day after the date that coverage is denied pursuant*
2 *to this section.*

3 (2) *The date on which the carrier ~~has ceased~~ ceases to be*
4 *financially impaired, as determined by the commissioner.*

5 (d) *Subdivision (c) shall not limit the carrier’s ability to renew*
6 *coverage already in force or relieve the carrier of the responsibility*
7 *to renew that coverage as described in Sections 10273.4, 10273.6,*
8 *and 10753.13.*

9 (e) *Coverage offered within a service area after the period*
10 *specified in subdivision (c) shall be subject to the requirements of*
11 *this section.*

12 SEC. 34. Section 10753.14 of the Insurance Code is amended
13 to read:

14 10753.14. (a) The premium rate for a health benefit plan
15 issued, amended, or renewed on or after January 1, 2014, shall
16 vary with respect to the particular coverage involved only by the
17 following:

18 (1) Age, pursuant to the age bands established by the United
19 States Secretary of Health and Human Services *and the age rating*
20 *curve established by the Centers for Medicare and Medicaid*
21 *Services pursuant to Section 2701(a)(3) of the federal Public Health*
22 *Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall*
23 *be determined ~~based on the individual’s birthday~~ using the*
24 *individual’s age as of the date of the plan issuance or renewal, as*
25 *applicable, and shall not vary by more than three to one for adults*
26 *like individuals of different age who are 21 years of age or older*
27 *as described in federal regulations adopted pursuant to Section*
28 *2701(a)(3) of the federal Public Health Service Act (42 U.S.C.*
29 *Sec. 300gg(a)(3)).*

30 (2) (A) Geographic region. ~~The~~ *Except as provided in*
31 *subparagraph (B), the geographic regions for purposes of rating*
32 *shall be the following:*

33 (i) Region 1 shall consist of the Counties of Alpine, Amador,
34 Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt,
35 Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey,
36 Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou,
37 Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas,
38 Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Sutter,
39 Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba, ~~Colusa,~~
40 Amador, Calaveras, and Tuolumne.

- 1 (ii) Region 2 shall consist of the Counties of *Fresno, Imperial,*
 2 *Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin,*
 3 *San Luis Obispo, Santa Cruz, Solano, Sonoma, Solano, and Marin*
 4 *and Stanislaus.*
- 5 ~~(iii) Region 3 shall consist of the Counties of Sacramento,~~
 6 ~~Placer, El Dorado, and Yolo.~~
- 7 ~~(iv)~~
- 8 ~~(iii) Region 4 3 shall consist of the County Counties of Alameda,~~
 9 ~~Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.~~
- 10 ~~(v) Region 5 shall consist of the County of Contra Costa.~~
- 11 ~~(vi) Region 6 shall consist of the County of Alameda.~~
- 12 ~~(vii) Region 7 shall consist of the County of Santa Clara.~~
- 13 ~~(viii) Region 8 shall consist of the County of San Mateo.~~
- 14 ~~(ix) Region 9 shall consist of the Counties of Santa Cruz,~~
 15 ~~Monterey, and San Benito.~~
- 16 ~~(x) Region 10 shall consist of the Counties of San Joaquin,~~
 17 ~~Stanislaus, Merced, Mariposa, and Tulare.~~
- 18 ~~(xi) Region 11 shall consist of the Counties of Madera, Fresno,~~
 19 ~~and Kings.~~
- 20 ~~(xii)~~
- 21 ~~(iv) Region 12 4 shall consist of the Counties of San Luis~~
 22 ~~Obispo, Orange, Santa Barbara, and Ventura.~~
- 23 ~~(xiii) Region 13 shall consist of the Counties of Mono, Inyo,~~
 24 ~~and Imperial.~~
- 25 ~~(xiv) Region 14 shall consist of the County of Kern.~~
- 26 ~~(xv)~~
- 27 ~~(v) Region 15 5 shall consist of the ZIP Codes in County of Los~~
 28 ~~Angeles County starting with 906 to 912, inclusive, 915, 917, 918,~~
 29 ~~and 935.~~
- 30 ~~(xvi) Region 16 shall consist of the ZIP Codes in Los Angeles~~
 31 ~~County other than those identified in clause (xv).~~
- 32 ~~(xvii) Region 17 shall consist of the Counties of San Bernardino~~
 33 ~~and Riverside.~~
- 34 ~~(xviii) Region 18 shall consist of the County of Orange.~~
- 35 ~~(xix)~~
- 36 ~~(vi) Region 19 6 shall consist of the County Counties of~~
 37 ~~Riverside, San Bernardino, and San Diego.~~
- 38 (B) For the 2015 plan year and plan years thereafter, the
 39 geographic regions for purposes of rating shall be the following,
 40 subject to federal approval if required pursuant to Section 2701

1 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg)
2 and obtained by the department and the Department of Managed
3 Health Care by July 1, 2014:

4 (i) Region 1 shall consist of the Counties of Alpine, Amador,
5 Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake,
6 Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra,
7 Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

8 (ii) Region 2 shall consist of the Counties of Marin, Napa,
9 Solano, and Sonoma.

10 (iii) Region 3 shall consist of the Counties of El Dorado, Placer,
11 Sacramento, and Yolo.

12 (iv) Region 4 shall consist of the Counties of Alameda, Contra
13 Costa, San Francisco, San Mateo, and Santa Clara.

14 (v) Region 5 shall consist of the Counties of Monterey, San
15 Benito, and Santa Cruz.

16 (vi) Region 6 shall consist of the Counties of Fresno, Kings,
17 Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.

18 (vii) Region 7 shall consist of the Counties of San Luis Obispo,
19 Santa Barbara, and Ventura.

20 (viii) Region 8 shall consist of the Counties of Imperial, Inyo,
21 Kern, and Mono.

22 (ix) Region 9 shall consist of the ZIP Codes in Los Angeles
23 County starting with 906 to 912, inclusive, 915, 917, 918, and 935.

24 (x) Region 10 shall consist of the ZIP Codes in Los Angeles
25 County other than those identified in clause (ix).

26 (xi) Region 11 shall consist of the Counties of San Bernardino
27 and Riverside.

28 (xii) Region 12 shall consist of the County of Orange.

29 (xiii) Region 13 shall consist of the County of San Diego.

30 ~~(B)~~

31 (C) No later than June 1, 2017, the department, in collaboration
32 with the Exchange and the Department of Managed Health Care,
33 shall review the geographic rating regions specified in this
34 paragraph and the impacts of those regions on the health care
35 coverage market in California, and make a report to the appropriate
36 policy committees of the Legislature.

37 (3) Whether the health benefit plan covers an individual or
38 family, as described in PPACA.

39 (b) The rate for a health benefit plan subject to this section shall
40 not vary by any factor not described in this section.

1 (c) *The total premium charged to a small employer pursuant to*
 2 *this section shall be determined by summing the premiums of*
 3 *covered employees and dependents in accordance with Section*
 4 *147.102(c)(1) of Title 45 of the Code of Federal Regulations.*

5 (e)

6 (d) The rating period for rates subject to this section shall be no
 7 less than 12 months from the date of issuance or renewal of the
 8 health benefit plan.

9 (d)

10 ~~This section shall become inoperative if Section 2701 of the~~
 11 ~~federal Public Health Service Act (42 U.S.C. Sec. 300gg), as added~~
 12 ~~by Section 1201 of PPACA, is repealed, in which case rates for~~
 13 ~~health benefit plans subject to this section shall instead be subject~~
 14 ~~to Section 10714, to the extent permitted by federal law, and all~~
 15 ~~references to this section shall be deemed to be references to~~
 16 ~~Section 10714.~~

17 SEC. 35. Section 10901.3 of the Insurance Code is amended
 18 to read:

19 10901.3. (a) (1) After the federally eligible defined individual
 20 submits a completed application form for a health benefit plan,
 21 the carrier shall, within 30 days, notify the individual of the
 22 individual's actual premium charges for that health benefit plan
 23 design. In no case shall the premium charged for any health benefit
 24 plan identified in subdivision (d) of Section 10785 exceed the
 25 following amounts:

26 (A) For health benefit plans that offer services through a
 27 preferred provider arrangement, the average premium paid by a
 28 subscriber of the Major Risk Medical Insurance Program who is
 29 of the same age and resides in the same geographic area as the
 30 federally eligible defined individual. However, for federally
 31 qualified individuals who are between the ages of 60 and 64,
 32 inclusive, the premium shall not exceed the average premium paid
 33 by a subscriber of the Major Risk Medical Insurance Program who
 34 is 59 years of age and resides in the same geographic area as the
 35 federally eligible defined individual.

36 (B) For health benefit plans identified in subdivision (d) of
 37 Section 10785 that do not offer services through a preferred
 38 provider arrangement, 170 percent of the standard premium charged
 39 to an individual who is of the same age and resides in the same
 40 geographic area as the federally eligible defined individual.

1 However, for federally qualified individuals who are between the
2 ages of 60 and 64, inclusive, the premium shall not exceed 170
3 percent of the standard premium charged to an individual who is
4 59 years of age and resides in the same geographic area as the
5 federally eligible defined individual. The individual shall have 30
6 days in which to exercise the right to buy coverage at the quoted
7 premium rates.

8 (2) A carrier may adjust the premium based on family size, not
9 to exceed the following amounts:

10 (A) For health benefit plans that offer services through a
11 preferred provider arrangement, the average of the Major Risk
12 Medical Insurance Program rate for families of the same size that
13 reside in the same geographic area as the federally eligible defined
14 individual.

15 (B) For health benefit plans identified in subdivision (d) of
16 Section 10785 that do not offer services through a preferred
17 provider arrangement, 170 percent of the standard premium charged
18 to a family that is of the same size and resides in the same
19 geographic area as the federally eligible defined individual.

20 (b) When a federally eligible defined individual submits a
21 premium payment, based on the quoted premium charges, and that
22 payment is delivered or postmarked, whichever occurs earlier,
23 within the first 15 days of the month, coverage shall begin no later
24 than the first day of the following month. When that payment is
25 neither delivered or postmarked until after the 15th day of a month,
26 coverage shall become effective no later than the first day of the
27 second month following delivery or postmark of the payment.

28 (c) During the first 30 days after the effective date of the health
29 benefit plan, the individual shall have the option of changing
30 coverage to a different health benefit plan design offered by the
31 same carrier. If the individual notified the plan of the change within
32 the first 15 days of a month, coverage under the new health benefit
33 plan shall become effective no later than the first day of the
34 following month. If an enrolled individual notified the carrier of
35 the change after the 15th day of a month, coverage under the health
36 benefit plan shall become effective no later than the first day of
37 the second month following notification.

38 (d) *This section shall remain in effect only until January 1, 2014,*
39 *or the 91st calendar day following the adjournment of the 2013–14*
40 *First Extraordinary Session, whichever date is later, and as of*

1 *that date is repealed, unless a later enacted statute, that becomes*
2 *operative on or before that date, deletes or extends the date on*
3 *which it is repealed.*

4 SEC. 36. Section 10901.3 is added to the Insurance Code, to
5 read:

6 10901.3. (a) After the federally eligible defined individual
7 submits a completed application form for a health benefit plan,
8 the carrier shall, within 30 days, notify the individual of the
9 individual's actual premium charges for that health benefit plan
10 design. In no case shall the premium charged for any health benefit
11 plan identified in subdivision (d) of Section 10785 exceed the
12 premium for the second lowest cost silver plan of the individual
13 market in the rating area in which the individual resides which is
14 offered through the California Health Benefit Exchange established
15 under Title 22 (commencing with Section 100500) of the
16 Government Code, as described in Section 36B(b)(3)(B) of Title
17 26 of the United States Code.

18 (b) When a federally eligible defined individual submits a
19 premium payment, based on the quoted premium charges, and that
20 payment is delivered or postmarked, whichever occurs earlier,
21 within the first 15 days of the month, coverage shall begin no later
22 than the first day of the following month. When that payment is
23 neither delivered or postmarked until after the 15th day of a month,
24 coverage shall become effective no later than the first day of the
25 second month following delivery or postmark of the payment.

26 (c) During the first 30 days after the effective date of the health
27 benefit plan, the individual shall have the option of changing
28 coverage to a different health benefit plan design offered by the
29 same carrier. If the individual notified the plan of the change within
30 the first 15 days of a month, coverage under the new health benefit
31 plan shall become effective no later than the first day of the
32 following month. If an enrolled individual notified the carrier of
33 the change after the 15th day of a month, coverage under the health
34 benefit plan shall become effective no later than the first day of
35 the second month following notification.

36 (d) This section shall become operative on January 1, 2014, or
37 the 91st calendar day following the adjournment of the 2013–14
38 First Extraordinary Session, whichever date is later.

39 SEC. 37. Section 10901.9 of the Insurance Code is amended
40 to read:

1 10901.9. Commencing January 1, 2001, premiums for health
2 benefit plans offered, delivered, amended, or renewed by carriers
3 shall be subject to the following requirements:

4 (a) The premium for new business for a federally eligible defined
5 individual shall not exceed the following amounts:

6 (1) For health benefit plans identified in subdivision (d) of
7 Section 10785 that offer services through a preferred provider
8 arrangement, the average premium paid by a subscriber of the
9 Major Risk Medical Insurance Program who is of the same age
10 and resides in the same geographic area as the federally eligible
11 defined individual. However, for federally qualified individuals
12 who are between the ages of 60 to 64, inclusive, the premium shall
13 not exceed the average premium paid by a subscriber of the Major
14 Risk Medical Insurance Program who is 59 years of age and resides
15 in the same geographic area as the federally eligible defined
16 individual.

17 (2) For health benefit plans identified in subdivision (d) of
18 Section 10785 that do not offer services through a preferred
19 provider arrangement, 170 percent of the standard premium charged
20 to an individual who is of the same age and resides in the same
21 geographic area as the federally eligible defined individual.
22 However, for federally qualified individuals who are between the
23 ages of 60 to 64, inclusive, the premium shall not exceed 170
24 percent of the standard premium charged to an individual who is
25 59 years of age and resides in the same geographic area as the
26 federally eligible defined individual.

27 (b) The premium for in force business for a federally eligible
28 defined individual shall not exceed the following amounts:

29 (1) For health benefit plans identified in subdivision (d) of
30 Section 10785 that offer services through a preferred provider
31 arrangement, the average premium paid by a subscriber of the
32 Major Risk Medical Insurance Program who is of the same age
33 and resides in the same geographic area as the federally eligible
34 defined individual. However, for federally qualified individuals
35 who are between the ages of 60 and 64, inclusive, the premium
36 shall not exceed the average premium paid by a subscriber of the
37 Major Risk Medical Insurance Program who is 59 years of age
38 and resides in the same geographic area as the federally eligible
39 defined individual.

1 (2) For health benefit plans identified in subdivision (d) of
2 Section 10785 that do not offer services through a preferred
3 provider arrangement, 170 percent of the standard premium charged
4 to an individual who is of the same age and resides in the same
5 geographic area as the federally eligible defined individual.
6 However, for federally qualified individuals who are between the
7 ages of 60 and 64, inclusive, the premium shall not exceed 170
8 percent of the standard premium charged to an individual who is
9 59 years of age and resides in the same geographic area as the
10 federally eligible defined individual. The premium effective on
11 January 1, 2001, shall apply to in force business at the earlier of
12 either the time of renewal or July 1, 2001.

13 (c) The premium applied to a federally eligible defined
14 individual may not increase by more than the following amounts:

15 (1) For health benefit plans identified in subdivision (d) of
16 Section 10785 that offer services through a preferred provider
17 arrangement, the average increase in the premiums charged to a
18 subscriber of the Major Risk Medical Insurance Program who is
19 of the same age and resides in the same geographic area as the
20 federally eligible defined individual.

21 (2) For health benefit plans identified in subdivision (d) of
22 Section 10785 that do not offer services through a preferred
23 provider arrangement, the increase in premiums charged to a
24 nonfederally qualified individual who is of the same age and resides
25 in the same geographic area as the federally defined eligible
26 individual. The premium for an eligible individual may not be
27 modified more frequently than every 12 months.

28 ~~(2)~~

29 (3) For a contract that a carrier has discontinued offering, the
30 premium applied to the first rating period of the new contract that
31 the federally eligible defined individual elects to purchase shall
32 be no greater than the premium applied in the prior rating period
33 to the discontinued contract.

34 *(d) This section shall remain in effect only until January 1, 2014,*
35 *or the 91st calendar day following the adjournment of the 2013–14*
36 *First Extraordinary Session, whichever date is later, and as of*
37 *that date is repealed, unless a later enacted statute, that becomes*
38 *operative on or before that date, deletes or extends the date on*
39 *which it is repealed.*

1 SEC. 38. Section 10901.9 is added to the Insurance Code, to
2 read:

3 10901.9. (a) Commencing on the date on which the act adding
4 this section becomes operative, premiums for health benefit plans
5 offered, delivered, amended, or renewed by carriers shall be subject
6 to the following requirements:

7 (1) The premium for in force or new business for a federally
8 eligible defined individual shall not exceed the premium for the
9 second lowest cost silver plan of the individual market in the rating
10 area in which the individual resides which is offered through the
11 California Health Benefit Exchange established under Title 22
12 (commencing with Section 100500) of the Government Code, as
13 described in Section 36B(b)(3)(B) of Title 26 of the United States
14 Code.

15 (2) For a contract that a carrier has discontinued offering, the
16 premium applied to the first rating period of the new contract that
17 the federally eligible defined individual elects to purchase shall
18 be no greater than the premium applied in the prior rating period
19 to the discontinued contract.

20 (b) This section shall become operative on January 1, 2014, or
21 the 91st calendar day following the adjournment of the 2013–14
22 First Extraordinary Session, whichever date is later.

23 SEC. 39. Section 10902.4 of the Insurance Code is repealed.

24 ~~10902.4. Carriers and health care service plans that offer~~
25 ~~contracts to individuals may elect to establish a mechanism or~~
26 ~~method to share in the financing of high-risk individuals. This~~
27 ~~mechanism or method shall be established through a committee~~
28 ~~of all carriers and health care service plans offering coverage to~~
29 ~~individuals by July 1, 2002, and shall be implemented by January~~
30 ~~1, 2003. If carriers and health care service plans wish to establish~~
31 ~~a risk-sharing mechanism but cannot agree on the terms and~~
32 ~~conditions of such an agreement, the Managed Risk Medical~~
33 ~~Insurance Board shall develop a risk-sharing mechanism or method~~
34 ~~by January 1, 2003, and it shall be implemented by July 1, 2003.~~

35 SEC. 40. The heading of Chapter 9.7 (commencing with
36 Section 10950) of Part 2 of Division 2 of the Insurance Code is
37 amended to read:

38
39 CHAPTER 9.7. ~~INDIVIDUAL~~ CHILD ACCESS TO HEALTH
40 INSURANCE

1 SEC. 41. Section 10954 of the Insurance Code is amended to
2 read:

3 10954. (a) A carrier may use the following characteristics of
4 an eligible child for purposes of establishing the rate of the health
5 benefit plan for that child, where consistent with federal regulations
6 under PPACA: age, geographic region, and family composition,
7 plus the health benefit plan selected by the child or the responsible
8 party for a child.

9 (b) From the effective date of this chapter to December 31,
10 2013, inclusive, rates for a child applying for coverage shall be
11 subject to the following limitations:

12 (1) During any open enrollment period or for late enrollees, the
13 rate for any child due to health status shall not be more than two
14 times the standard risk rate for a child.

15 (2) The rate for a child shall be subject to a 20-percent surcharge
16 above the highest allowable rate on a child applying for coverage
17 who is not a late enrollee and who failed to maintain coverage with
18 any carrier or health care service plan for the 90-day period prior
19 to the date of the child's application. The surcharge shall apply
20 for the 12-month period following the effective date of the child's
21 coverage.

22 (3) If expressly permitted under PPACA and any rules,
23 regulations, or guidance issued pursuant to that act, a carrier may
24 rate a child based on health status during any period other than an
25 open enrollment period if the child is not a late enrollee.

26 (4) If expressly permitted under PPACA and any rules,
27 regulations, or guidance issued pursuant to that act, a carrier may
28 condition an offer or acceptance of coverage on any preexisting
29 condition or other health status-related factor for a period other
30 than an open enrollment period and for a child who is not a late
31 enrollee.

32 (c) For any individual health benefit plan issued, sold, or
33 renewed prior to December 31, 2013, the carrier shall provide to
34 a child or responsible party for a child a notice that states the
35 following:

36
37 "Please consider your options carefully before failing to maintain
38 or ~~renew~~ *renewing* coverage for a child for whom you are
39 responsible. If you attempt to obtain new individual coverage for

1 that child, the premium for the same coverage may be higher than
2 the premium you pay now.”

3
4 (d) A child who applied for coverage between September 23,
5 2010, and the end of the initial enrollment period shall be deemed
6 to have maintained coverage during that period.

7 ~~(e) Effective January 1, 2014, except for individual~~
8 ~~grandfathered health plan coverage, the rate for any child shall be~~
9 ~~identical to the standard risk rate.~~

10 ~~(f)~~

11 (e) Carriers ~~may~~ shall not require documentation from applicants
12 relating to their coverage history.

13 (f) (1) *On and after the operative date of the act adding this*
14 *subdivision, and until January 1, 2014, a carrier shall provide a*
15 *notice to all applicants for coverage under this chapter and to all*
16 *insureds, or the responsible party for an insured, renewing*
17 *coverage under this chapter that contains the following*
18 *information:*

19 (A) *Information about the open enrollment period provided*
20 *under Section 10965.3.*

21 (B) *An explanation that obtaining coverage during the open*
22 *enrollment period described in Section 10965.3 will not affect the*
23 *effective dates of coverage for coverage purchased pursuant to*
24 *this chapter unless the applicant cancels that coverage.*

25 (C) *An explanation that coverage purchased pursuant to this*
26 *chapter shall be effective as required under subdivision (d) of*
27 *Section 10951 and that such coverage shall not prevent an*
28 *applicant from obtaining new coverage during the open enrollment*
29 *period described in Section 10965.3.*

30 (D) *Information about the Medi-Cal program and the Healthy*
31 *Families Program and about subsidies available through the*
32 *California Health Benefit Exchange.*

33 (2) *The notice described in paragraph (1) shall be in plain*
34 *language and 14-point type.*

35 (3) *The department may adopt a model notice to be used by*
36 *carriers in order to comply with this subdivision, and shall consult*
37 *with the Department of Managed Health Care in adopting that*
38 *model notice. Use of the model notice shall not require prior*
39 *approval of the department. Any model notice designated by the*
40 *department for purposes of this section shall not be subject to the*

1 *Administrative Procedure Act (Chapter 3.5 (commencing with*
 2 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*
 3 *Code).*

4 SEC. 42. Section 10960.5 is added to the Insurance Code, to
 5 read:

6 10960.5. This chapter shall become inoperative on January 1,
 7 2014, or the 91st calendar day following the adjournment of the
 8 2013–14 First Extraordinary Session, whichever date is later.

9 SEC. 43. Chapter 9.9 (commencing with Section 10965) is
 10 added to Part 2 of Division 2 of the Insurance Code, to read:

11
 12 CHAPTER 9.9. INDIVIDUAL ACCESS TO HEALTH INSURANCE
 13

14 10965. For purposes of this chapter, the following definitions
 15 shall apply:

16 (a) “Child” means a child described in Section 22775 of the
 17 Government Code and subdivisions (n) to (p), inclusive, of Section
 18 599.500 of Title 2 of the California Code of Regulations.

19 (b) “Dependent” means the spouse or registered domestic
 20 partner, or child, of an individual, subject to applicable terms of
 21 the health benefit plan.

22 (c) “Exchange” means the California Health Benefit Exchange
 23 created by Section 100500 of the Government Code.

24 (d) “Grandfathered health plan” has the same meaning as that
 25 term is defined in Section 1251 of PPACA.

26 (e) “Health benefit plan” means any individual or group policy
 27 of health insurance, as defined in Section 106. The term does not
 28 include a health insurance policy that provides excepted benefits,
 29 as described in Sections 2722 and 2791 of the federal Public Health
 30 Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91),
 31 subject to Section 10965.01, a health insurance conversion policy
 32 offered pursuant to Section 12682.1, a health insurance policy
 33 provided in the Medi-Cal program (Chapter 7 (commencing with
 34 Section 14000) of Part 3 of Division 9 of the Welfare and
 35 Institutions Code), the Healthy Families Program (Part 6.2
 36 (commencing with Section 12693) of Division 2), the Access for
 37 Infants and Mothers Program (Part 6.3 (commencing with Section
 38 12695) of Division 2), or the program under Part 6.4 (commencing
 39 with Section 12699.50) of Division 2, or a health insurance policy
 40 offered to a federally eligible defined individual under Chapter

1 8.5 (commencing with Section 10785), to the extent consistent
2 with PPACA.

3 (f) “Policy year” has the meaning set forth in Section 144.103
4 of Title 45 of the Code of Federal Regulations.

5 (g) “PPACA” means the federal Patient Protection and
6 Affordable Care Act (Public Law 111-148), as amended by the
7 federal Health Care and Education Reconciliation Act of 2010
8 (Public Law 111-152), and any rules, regulations, or guidance
9 issued pursuant to that law.

10 (h) “Preexisting condition provision” means a policy provision
11 that excludes coverage for charges or expenses incurred during a
12 specified period following the insured’s effective date of coverage,
13 as to a condition for which medical advice, diagnosis, care, or
14 treatment was recommended or received during a specified period
15 immediately preceding the effective date of coverage.

16 (i) “Rating period” means the period for which premium rates
17 established by an insurer are in effect.

18 (j) “Registered domestic partner” means a person who has
19 established a domestic partnership as described in Section 297 of
20 the Family Code.

21 10965.01. (a) For purposes of this chapter, “health benefit
22 plan” does not include policies or certificates of specified disease
23 or hospital confinement indemnity provided that the carrier offering
24 those policies or certificates complies with the following:

25 (1) The carrier files, on or before March 1 of each year, a
26 certification with the commissioner that contains the statement
27 and information described in paragraph (2).

28 (2) The certification required in paragraph (1) shall contain the
29 following:

30 (A) A statement from the carrier certifying that policies or
31 certificates described in this section (i) are being offered and
32 marketed as supplemental health insurance and not as a substitute
33 for coverage that provides essential health benefits as defined by
34 the state pursuant to Section 1302 of PPACA, and (ii) the disclosure
35 forms as described in Section 10603 contains the following
36 statement prominently on the first page:

37
38 “This is a supplement to health insurance. It is not a substitute
39 for essential health benefits or minimum essential coverage as
40 defined in federal law.”

1
 2 (B) A summary description of each policy or certificate
 3 described in this section, including the average annual premium
 4 rates, or range of premium rates in cases where premiums vary by
 5 age, gender, or other factors, charged for the policies and
 6 certificates in this state.

7 (3) In the case of a policy or certificate that is described in this
 8 section and that is offered for the first time in this state on or after
 9 January 1, 2013, the carrier files with the commissioner the
 10 information and statement required in paragraph (2) at least 30
 11 days prior to the date such a policy or certificate is issued or
 12 delivered in this state.

13 (b) As used in this section, “policies or certificates of specified
 14 disease” and “policies or certificates of hospital confinement
 15 indemnity” mean policies or certificates of insurance sold to an
 16 insured to supplement other health insurance coverage as specified
 17 in this section.

18 10965.1. Every health insurer offering individual health benefit
 19 plans shall, in addition to complying with the provisions of this
 20 part and rules adopted thereunder, comply with the provisions of
 21 this chapter.

22 10965.3. (a) (1) On and after October 1, 2013, a health insurer
 23 shall fairly and affirmatively offer, market, and sell all of the
 24 insurer’s health benefit plans that are sold in the individual market
 25 for policy years on or after January 1, 2014, to all individuals and
 26 dependents in each service area in which the insurer provides or
 27 arranges for the provision of health care services. A health insurer
 28 shall limit enrollment in individual health benefit plans to open
 29 enrollment periods and special enrollment periods as provided in
 30 subdivisions (c) and (d).

31 (2) A health insurer shall allow the policyholder of an individual
 32 health benefit plan to add a dependent to the policyholder’s health
 33 benefit plan at the option of the policyholder, consistent with the
 34 open enrollment, annual enrollment, and special enrollment period
 35 requirements in this section.

36 (3) A health insurer offering coverage in the individual market
 37 shall not reject the request of a policyholder during an open
 38 enrollment period to include a dependent of the policyholder as a
 39 dependent on an existing individual health benefit plan.

1 (b) An individual health benefit plan issued, amended, or
2 renewed on or after January 1, 2014, shall not impose any
3 preexisting condition provision upon any individual.

4 (c) A health insurer shall provide an initial open enrollment
5 period from October 1, 2013, to March 31, 2014, inclusive, and
6 annual enrollment periods for plan years on or after January 1,
7 2015, from October 15 to December 7, inclusive, of the preceding
8 calendar year.

9 (d) (1) Subject to paragraph (2), commencing January 1, 2014,
10 a health insurer shall allow an individual to enroll in or change
11 individual health benefit plans as a result of the following triggering
12 events:

13 (A) He or she or his or her dependent loses minimum essential
14 coverage. For purposes of this paragraph, both of the following
15 definitions shall apply:

16 (i) “Minimum essential coverage” has the same meaning as that
17 term is defined in subsection (f) of Section 5000A of the Internal
18 Revenue Code (26 U.S.C. Sec. 5000A).

19 (ii) “Loss of minimum essential coverage” includes, but is not
20 limited to, loss of that coverage due to the circumstances described
21 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
22 Code of Federal Regulations and the circumstances described in
23 Section 1163 of Title 29 of the United States Code. “Loss of
24 minimum essential coverage” also includes loss of that coverage
25 for a reason that is not due to the fault of the individual.

26 (iii) “Loss of minimum essential coverage” does not include
27 loss of that coverage due to the individual’s failure to pay
28 premiums on a timely basis or situations allowing for a rescission,
29 subject to clause (ii) and Sections 10119.2 and 10384.17.

30 (B) He or she gains a dependent or becomes a dependent.

31 (C) He or she is mandated to be covered pursuant to a valid
32 state or federal court order.

33 (D) He or she has been released from incarceration.

34 (E) His or her health benefit plan substantially violated a
35 material provision of the policy.

36 (F) He or she gains access to new health benefit plans as a result
37 of a permanent move.

38 (G) He or she was receiving services from a contracting provider
39 under another health benefit plan, as defined in Section 10965 or
40 Section 1399.845 of the Health and Safety Code for one of the

1 conditions described in subdivision (a) of Section 10133.56 and
2 that provider is no longer participating in the health benefit plan.

3 (H) He or she demonstrates to the Exchange, with respect to
4 health benefit plans offered through the Exchange, or to the
5 department, with respect to health benefit plans offered outside
6 the Exchange, that he or she did not enroll in a health benefit plan
7 during the immediately preceding enrollment period available to
8 the individual because he or she was misinformed that he or she
9 was covered under minimum essential coverage.

10 (I) With respect to individual health benefit plans offered
11 through the Exchange, in addition to the triggering events listed
12 in this paragraph, any other events listed in Section 155.420(d) of
13 Title 45 of the Code of Federal Regulations.

14 (2) With respect to individual health benefit plans offered
15 outside the Exchange, an individual shall have 63 days from the
16 date of a triggering event identified in paragraph (1) to apply for
17 coverage from a health care service plan subject to this section.
18 With respect to individual health benefit plans offered through the
19 Exchange, an individual shall have 63 days from the date of a
20 triggering event identified in paragraph (1) to select a plan offered
21 through the Exchange, unless a longer period is provided in Part
22 155 (commencing with Section 155.10) of Subchapter B of Subtitle
23 A of Title 45 of the Code of Federal Regulations.

24 (e) With respect to individual health benefit plans offered
25 through the Exchange, the following provisions shall apply:

26 (1) The effective date of coverage selected pursuant to this
27 section shall be consistent with the dates specified in Section
28 155.410 or 155.420 of Title 45 of the Code of Federal Regulations.

29 (2) Notwithstanding paragraph (1), in the case where an
30 individual acquires a dependent or becomes a dependent by
31 entering into a registered domestic partnership pursuant to Section
32 297 of the Family Code and applies for coverage of that domestic
33 partner consistent with subdivision (d), the coverage effective date
34 shall be the first day of the month following the date he or she
35 selects a plan through the Exchange, unless an earlier date is agreed
36 to under Section 155.420(b)(3) of Title 45 of the Code of Federal
37 Regulations.

38 (f) With respect to an individual health benefit plan offered
39 outside the Exchange, the following provisions shall apply:

1 (1) After an individual submits a completed application form
2 for a plan, the insurer shall, within 30 days, notify the individual
3 of the individual's actual premium charges for that plan established
4 in accordance with Section 10965.9. The individual shall have 30
5 days in which to exercise the right to buy coverage at the quoted
6 premium charges.

7 (2) With respect to an individual health benefit plan for which
8 an individual applies during the initial open enrollment period
9 described in subdivision (c), when the policyholder submits a
10 premium payment, based on the quoted premium charges, and that
11 payment is delivered or postmarked, whichever occurs earlier, by
12 December 15, 2013, coverage under the individual health benefit
13 plan shall become effective no later than January 1, 2014. When
14 that payment is delivered or postmarked within the first 15 days
15 of any subsequent month, coverage shall become effective no later
16 than the first day of the following month. When that payment is
17 delivered or postmarked between December 16, 2013, and
18 December 31, 2013, inclusive, or after the 15th day of any
19 subsequent month, coverage shall become effective no later than
20 the first day of the second month following delivery or postmark
21 of the payment.

22 (3) With respect to an individual health benefit plan for which
23 an individual applies during the annual open enrollment period
24 described in subdivision (c), when the individual submits a
25 premium payment, based on the quoted premium charges, and that
26 payment is delivered or postmarked, whichever occurs later, by
27 December 15, coverage shall become effective as of the following
28 January 1. When that payment is delivered or postmarked within
29 the first 15 days of any subsequent month, coverage shall become
30 effective no later than the first day of the following month. When
31 that payment is delivered or postmarked between December 16
32 and December 31, inclusive, or after the 15th day of any subsequent
33 month, coverage shall become effective no later than the first day
34 of the second month following delivery or postmark of the
35 payment.

36 (4) With respect to an individual health benefit plan for which
37 an individual applies during a special enrollment period described
38 in subdivision (d), the following provisions shall apply:

39 (A) When the individual submits a premium payment, based
40 on the quoted premium charges, and that payment is delivered or

1 postmarked, whichever occurs earlier, within the first 15 days of
2 the month, coverage under the plan shall become effective no later
3 than the first day of the following month. When the premium
4 payment is neither delivered nor postmarked until after the 15th
5 day of the month, coverage shall become effective no later than
6 the first day of the second month following delivery or postmark
7 of the payment.

8 (B) Notwithstanding subparagraph (A), in the case of a birth,
9 adoption, or placement for adoption, the coverage shall be effective
10 on the date of birth, adoption, or placement for adoption.

11 (C) Notwithstanding subparagraph (A), in the case of marriage
12 or becoming a registered domestic partner or in the case where a
13 qualified individual loses minimum essential coverage, the
14 coverage effective date shall be the first day of the month following
15 the date the insurer receives the request for special enrollment.

16 (g) (1) A health insurer shall not establish rules for eligibility,
17 including continued eligibility, of any individual to enroll under
18 the terms of an individual health benefit plan based on any of the
19 following factors:

20 (A) Health status.

21 (B) Medical condition, including physical and mental illnesses.

22 (C) Claims experience.

23 (D) Receipt of health care.

24 (E) Medical history.

25 (F) Genetic information.

26 (G) Evidence of insurability, including conditions arising out
27 of acts of domestic violence.

28 (H) Disability.

29 (I) Any other health status-related factor as determined by any
30 federal regulations, rules, or guidance issued pursuant to Section
31 2705 of the federal Public Health Service Act.

32 (2) Notwithstanding subdivision (c) of Section 10291.5, a health
33 insurer shall not require an individual applicant or his or her
34 dependent to fill out a health assessment or medical questionnaire
35 prior to enrollment under an individual health benefit plan. A health
36 insurer shall not acquire or request information that relates to a
37 health status-related factor from the applicant or his or her
38 dependent or any other source prior to enrollment of the individual.

39 (h) (1) A health insurer shall consider the claims experience of
40 all insureds in all individual health benefit plans offered in the

1 state that are subject to subdivision (a), including those insureds
2 who do not enroll in the plans through the Exchange, to be
3 members of a single risk pool.

4 (2) Each policy year, a health insurer shall establish an index
5 rate for the individual market in the state based on the total
6 combined claims costs for providing essential health benefits, as
7 defined pursuant to Section 1302 of PPACA, within the single risk
8 pool required under paragraph (1). The index rate shall be adjusted
9 on a market-wide basis based on the total expected market-wide
10 payments and charges under the risk adjustment and reinsurance
11 programs established for the state pursuant to Sections 1343 and
12 1341 of PPACA. The premium rate for all of the health insurer's
13 health benefit plans in the individual market shall use the applicable
14 index rate, as adjusted for total expected market-wide payments
15 and charges under the risk adjustment and reinsurance programs
16 established for the state pursuant to Sections 1343 and 1341 of
17 PPACA, subject only to the adjustments permitted under paragraph
18 (3).

19 (3) A health insurer may vary premiums rates for a particular
20 health benefit plan from its index rate based only on the following
21 actuarially justified plan-specific factors:

22 (A) The actuarial value and cost-sharing design of the health
23 benefit plan.

24 (B) The health benefit plan's provider network, delivery system
25 characteristics, and utilization management practices.

26 (C) The benefits provided under the health benefit plan that are
27 in addition to the essential health benefits, as defined pursuant to
28 Section 1302 of PPACA. These additional benefits shall be pooled
29 with similar benefits within the single risk pool required under
30 paragraph (1) and the claims experience from those benefits shall
31 be utilized to determine rate variations for plans that offer those
32 benefits in addition to essential health benefits.

33 (D) With respect to catastrophic plans, as described in subsection
34 (e) of Section 1302 of PPACA, the expected impact of the specific
35 eligibility categories for those plans.

36 (i) This section shall only apply with respect to individual health
37 benefit plans for policy years on or after January 1, 2014.

38 (j) This section shall not apply to an individual health benefit
39 plan that is a grandfathered health plan.

1 10965.5. (a) No health insurer or agent or broker shall, directly
2 or indirectly, engage in the following activities:

3 (1) Encourage or direct an individual to refrain from filing an
4 application for individual coverage with an insurer because of the
5 health status, claims experience, industry, occupation, or
6 geographic location, provided that the location is within the
7 insurer’s approved service area, of the individual.

8 (2) Encourage or direct an individual to seek individual coverage
9 from another health care service plan or health insurer or the
10 Exchange because of the health status, claims experience, industry,
11 occupation, or geographic location, provided that the location is
12 within the insurer’s approved service area, of the individual.

13 (3) Employ marketing practices or benefit designs that will have
14 the effect of discouraging the enrollment of individuals with
15 significant health needs.

16 (b) A health insurer shall not, directly or indirectly, enter into
17 any contract, agreement, or arrangement with a broker or agent
18 that provides for or results in the compensation paid to a broker
19 or agent for the sale of an individual health benefit plan to be varied
20 because of the health status, claims experience, industry,
21 occupation, or geographic location of the individual. This
22 subdivision does not apply to a compensation arrangement that
23 provides compensation to a broker or agent on the basis of
24 percentage of premium, provided that the percentage shall not vary
25 because of the health status, claims experience, industry,
26 occupation, or geographic area of the individual.

27 (c) This section shall only apply with respect to individual health
28 benefit plans for policy years on or after January 1, 2014.

29 (d) This section shall be enforced in the same manner as Section
30 790.03, including through Sections 790.05 and 790.035.

31 10965.7. (a) All individual health benefit plans shall conform
32 to the requirements of Sections 10112.1, 10127.18, 10273.6, and
33 12682.1, and any other requirements imposed by this code, and
34 shall be renewable at the option of the insured except as permitted
35 to be canceled, rescinded, or not renewed pursuant to Section
36 10273.6.

37 (b) Any insurer that ceases to offer for sale new individual health
38 benefit plans pursuant to Section 10273.6 shall continue to be
39 governed by this chapter with respect to business conducted under
40 this chapter.

1 10965.9. (a) With respect to individual health benefit plans
2 issued, amended, or renewed on or after January 1, 2014, a health
3 insurer may use only the following characteristics of an individual,
4 and any dependent thereof, for purposes of establishing the rate
5 of the individual health benefit plan covering the individual and
6 the eligible dependents thereof, along with the health benefit plan
7 selected by the individual:

8 (1) Age, pursuant to the age bands established by the United
9 States Secretary of Health and Human Services and the age rating
10 curve established by the federal Centers for Medicare and Medicaid
11 Services pursuant to Section 2701(a)(3) of the federal Public Health
12 Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall
13 be determined using the individual's age as of the date of the plan
14 issuance or renewal, as applicable, and shall not vary by more than
15 three to one for like individuals of different age who are age 21 or
16 older as described in federal regulations adopted pursuant to
17 Section 2701(a)(3) of the federal Public Health Service Act (42
18 U.S.C. Sec. 300gg(a)(3)).

19 (2) (A) Geographic region. Except as provided in subparagraph
20 (B), the geographic regions for purposes of rating shall be the
21 following:

22 (i) Region 1 shall consist of the Counties of Alpine, Amador,
23 Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt,
24 Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey,
25 Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou,
26 Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

27 (ii) Region 2 shall consist of the Counties of Fresno, Imperial,
28 Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin,
29 San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

30 (iii) Region 3 shall consist of the Counties of Alameda, Contra
31 Costa, Marin, San Francisco, San Mateo, and Santa Clara.

32 (iv) Region 4 shall consist of the Counties of Orange, Santa
33 Barbara, and Ventura.

34 (v) Region 5 shall consist of the County of Los Angeles.

35 (vi) Region 6 shall consist of the Counties of Riverside, San
36 Bernardino, and San Diego.

37 (B) For the 2015 plan year and plan years thereafter, the
38 geographic regions for purposes of rating shall be the following,
39 subject to federal approval if required pursuant to Section 2701 of
40 the federal Public Health Service Act (42 U.S.C. Sec. 300gg) and

- 1 obtained by the department and the Department of Managed Health
2 Care by July 1, 2014:
- 3 (i) Region 1 shall consist of the Counties of Alpine, Amador,
4 Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake,
5 Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra,
6 Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.
- 7 (ii) Region 2 shall consist of the Counties of Marin, Napa,
8 Solano, and Sonoma.
- 9 (iii) Region 3 shall consist of the Counties of El Dorado, Placer,
10 Sacramento, and Yolo.
- 11 (iv) Region 4 shall consist of the Counties of Alameda, Contra
12 Costa, San Francisco, San Mateo, and Santa Clara.
- 13 (v) Region 5 shall consist of the Counties of Monterey, San
14 Benito, and Santa Cruz.
- 15 (vi) Region 6 shall consist of the Counties of Fresno, Kings,
16 Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.
- 17 (vii) Region 7 shall consist of the Counties of San Luis Obispo,
18 Santa Barbara, and Ventura.
- 19 (viii) Region 8 shall consist of the Counties of Imperial, Inyo,
20 Kern, and Mono.
- 21 (ix) Region 9 shall consist of the ZIP Codes in Los Angeles
22 County starting with 906 to 912, inclusive, 915, 917, 918, and 935.
- 23 (x) Region 10 shall consist of the ZIP Codes in Los Angeles
24 County other than those identified in clause (ix).
- 25 (xi) Region 11 shall consist of the Counties of San Bernardino
26 and Riverside.
- 27 (xii) Region 12 shall consist of the County of Orange.
- 28 (xiii) Region 13 shall consist of the County of San Diego.
- 29 (C) No later than June 1, 2017, the department, in collaboration
30 with the Exchange and the Department of Managed Health Care,
31 shall review the geographic rating regions specified in this
32 paragraph and the impacts of those regions on the health care
33 coverage market in California, and make a report to the appropriate
34 policy committees of the Legislature.
- 35 (3) Whether the plan covers an individual or family, as described
36 in PPACA.
- 37 (b) The rate for a health benefit plan subject to this section shall
38 not vary by any factor not described in this section.
- 39 (c) With respect to family coverage under an individual health
40 benefit plan, the rating variation permitted under paragraph (1) of

1 subdivision (a) shall be applied based on the portion of the
2 premium attributable to each family member covered under the
3 plan. The total premium for family coverage shall be determined
4 by summing the premiums for each individual family member. In
5 determining the total premium for family members, premiums for
6 no more than the three oldest family members who are under age
7 21 shall be taken into account.

8 (d) The rating period for rates subject to this section shall be
9 from January 1 to December 31, inclusive.

10 (e) This section shall not apply to an individual health benefit
11 plan that is a grandfathered health plan.

12 (f) The requirement for submitting a report imposed under
13 subparagraph (B) of paragraph (2) of subdivision (a) is inoperative
14 on June 1, 2021, pursuant to Section 10231.5 of the Government
15 Code.

16 10965.11. (a) A health insurer shall not be required to offer
17 an individual health benefit plan or accept applications for the plan
18 pursuant to Section 10965.3 in the case of any of the following:

19 (1) To an individual who does not live or reside within the
20 insurer's approved service areas.

21 (2) (A) Within a specific service area or portion of a service
22 area, if the insurer reasonably anticipates and demonstrates to the
23 satisfaction of the commissioner both of the following:

24 (i) It will not have sufficient health care delivery resources to
25 ensure that health care services will be available and accessible to
26 the individual because of its obligations to existing insureds.

27 (ii) It is applying this subparagraph uniformly to all individuals
28 without regard to the claims experience of those individuals or any
29 health status-related factor relating to those individuals.

30 (B) A health insurer that cannot offer an individual health benefit
31 plan to individuals because it is lacking in sufficient health care
32 delivery resources within a service area or a portion of a service
33 area pursuant to subparagraph (A) shall not offer an individual
34 health benefit plan in that area until the later of the following dates:

35 (i) The 181st day after the date coverage is denied pursuant to
36 this paragraph.

37 (ii) The date the insurer notifies the commissioner that it has
38 the ability to deliver services to individuals, and certifies to the
39 commissioner that from the date of the notice it will enroll all
40 individuals requesting coverage in that area from the insurer.

1 (C) Subparagraph (B) shall not limit the insurer’s ability to
2 renew coverage already in force or relieve the insurer of the
3 responsibility to renew that coverage as described in Section
4 10273.6.

5 (D) Coverage offered within a service area after the period
6 specified in subparagraph (B) shall be subject to this section.

7 (b) (1) A health insurer may decline to offer an individual health
8 benefit plan to an individual if the insurer demonstrates to the
9 satisfaction of the commissioner both of the following:

10 (A) It does not have the financial reserves necessary to
11 underwrite additional coverage. In determining whether this
12 subparagraph has been satisfied, the commissioner shall consider,
13 but not be limited to, the insurer’s compliance with the
14 requirements of this part and the rules adopted under those
15 provisions.

16 (B) It is applying this subdivision uniformly to all individuals
17 without regard to the claims experience of those individuals or any
18 health status-related factor relating to those individuals.

19 (2) A health insurer that denies coverage to an individual under
20 paragraph (1) shall not offer coverage in the individual market
21 before the later of the following dates:

22 (A) The 181st day after the date coverage is denied pursuant to
23 this subdivision.

24 (B) The date the insurer demonstrates to the satisfaction of the
25 commissioner that the insurer has sufficient financial reserves
26 necessary to underwrite additional coverage.

27 (3) Paragraph (2) shall not limit the insurer’s ability to renew
28 coverage already in force or relieve the insurer of the responsibility
29 to renew that coverage as described in Section 10273.6.

30 (C) Coverage offered within a service area after the period
31 specified in paragraph (2) shall be subject to this section.

32 (c) Nothing in this chapter shall be construed to limit the
33 commissioner’s authority to develop and implement a plan of
34 rehabilitation for a health insurer whose financial viability or
35 organizational and administrative capacity has become impaired
36 to the extent permitted by PPACA.

37 10965.13. (a) A health insurer that receives an application for
38 an individual health benefit plan outside the Exchange during the
39 initial open enrollment period, an annual enrollment period, or a
40 special enrollment period described in Section 10965.3 shall inform

1 the applicant that he or she may be eligible for lower cost coverage
2 through the Exchange and shall inform the applicant of the
3 applicable enrollment period provided through the Exchange
4 described in Section 10965.3.

5 (b) On or before October 1, 2013, and annually thereafter, a
6 health insurer shall issue a notice to a policyholder enrolled in an
7 individual health benefit plan offered outside the Exchange. The
8 notice shall inform the policyholder that he or she may be eligible
9 for lower cost coverage through the Exchange and shall inform
10 the policyholder of the applicable open enrollment period provided
11 through the Exchange described in Section 10965.3.

12 (c) This section shall not apply where the individual health
13 benefit plan described in subdivision (a) or (b) is a grandfathered
14 health plan.

15 10965.15. (a) On or before October 1, 2013, and annually
16 thereafter, a health insurer shall issue the following notice to all
17 policyholders enrolled in an individual health benefit plan that is
18 a grandfathered health plan:

19
20 New improved health insurance options are available in
21 California. You currently have health insurance that is exempt
22 from many of the new requirements. For instance, your policy may
23 not include certain consumer protections that apply to other
24 policies, such as the requirement for the provision of preventive
25 health services without any cost sharing and the prohibition against
26 increasing your rates based on your health status. You have the
27 option to remain in your current policy or switch to a new policy.
28 Under the new rules, a health insurance company cannot deny your
29 application based on any health conditions you may have. For
30 more information about your options, please contact the California
31 Health Benefit Exchange, the Office of Patient Advocate, your
32 policy representative, an insurance broker, or a health care
33 navigator.

34
35 (b) Commencing October 1, 2013, a health insurer shall include
36 the notice described in subdivision (a) in any renewal material of
37 the individual grandfathered health plan and in any application for
38 dependent coverage under the individual grandfathered health
39 plan.

1 (c) A health insurer shall not advertise or market an individual
 2 health benefit plan that is a grandfathered health plan for purposes
 3 of enrolling a dependent of a policyholder into the plan for policy
 4 years on or after January 1, 2014. Nothing in this subdivision shall
 5 be construed to prohibit an individual enrolled in an individual
 6 grandfathered health plan from adding a dependent to that plan to
 7 the extent permitted by PPACA.

8 10965.16. Except as otherwise provided in this chapter, this
 9 chapter shall be implemented to the extent that it meets or exceeds
 10 the requirements set forth in PPACA.

11 SEC. 44. Part 6.25 (commencing with Section 12694.50) is
 12 added to Division 2 of the Insurance Code, to read:

13

14 PART 6.25. CHIP CONTINUATION COVERAGE

15

16 12694.50. For purposes of this part, the following definitions
 17 shall apply:

18 (a) "Board" means the Managed Risk Medical Insurance Board.

19 (b) "Department" means the State Department of Health Care
 20 Services.

21 (c) "Participating dental plan" means any of the following plans
 22 that is lawfully engaged in providing, arranging, paying for, or
 23 reimbursing the cost of personal dental services under insurance
 24 policies or health care service plan contracts, or membership
 25 contracts, in consideration of premiums or other periodic charges
 26 payable to it, and that, on or after January 1, 2012, has or had a
 27 contract with the board or the department to provide coverage to
 28 program subscribers:

29 (1) A dental insurer holding a valid outstanding certificate of
 30 authority from the commissioner.

31 (2) A specialized health care service plan as defined under
 32 subdivision (o) of Section 1345 of the Health and Safety Code.

33 (d) "Participating health plan" means any of the following plans
 34 that is lawfully engaged in providing, arranging, paying for, or
 35 reimbursing the cost of personal health care services under
 36 insurance policies or health care service plan contracts, medical
 37 and hospital service arrangements, or membership contracts, in
 38 consideration of premiums or other periodic charges payable to it,
 39 and that, on or after January 1, 2012, has or had a contract with

1 the board or the department to provide coverage to program
2 subscribers:

3 (1) A private health insurer holding a valid outstanding
4 certificate of authority from the commissioner.

5 (2) A health care service plan as defined under subdivision (f)
6 of Section 1345 of the Health and Safety Code, including a plan
7 operating as a geographic managed care plan pursuant to a contract
8 entered into under Article 2.91 (commencing with Section 14089)
9 of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions
10 Code.

11 (3) A county organized health system.

12 (e) “Participating vision care plan” means any of the following
13 plans that is lawfully engaged in providing, arranging, paying for,
14 or reimbursing the cost of personal vision services under insurance
15 policies or health care service plan contracts, or membership
16 contracts, in consideration of premiums or other periodic charges
17 payable to it, and that, on or after January 1, 2012, has or had a
18 contract with the board or the department to provide coverage to
19 program subscribers:

20 (1) A vision insurer holding a valid outstanding certificate of
21 authority from the commissioner.

22 (2) A specialized health care service plan as defined under
23 subdivision (o) of Section 1345 of the Health and Safety Code.

24 (f) “Program” means the federal Children’s Health Insurance
25 Program established in the state pursuant to Title XXI of the federal
26 Social Security Act and includes the program established under
27 Part 6.2 (commencing with Section 12693) and the transition of
28 the enrollees in that program pursuant to Section 14005.26 of the
29 Welfare and Institutions Code.

30 (g) “Qualified beneficiary” means an individual who meets all
31 of the following requirements:

32 (1) On or after January 1, 2012, received or receives coverage
33 under a participating dental, health, or vision plan under the
34 program.

35 (2) Was disenrolled or will be disenrolled from the program
36 due to loss of eligibility because of his or her age.

37 (3) Is not eligible for full scope benefits under the Medi-Cal
38 program.

39 (h) “Subscriber” means an individual who is eligible for and
40 enrolled in the program.

1 12694.52. (a) Until January 1, 2014, or the date that is six
2 months following the operative date of this part, whichever date
3 is later, every participating health, dental, and vision plan shall
4 offer coverage to a qualified beneficiary. The plan shall offer the
5 qualified beneficiary the same coverage that the beneficiary had
6 immediately prior to disenrollment from the program or coverage
7 with benefits that are most equivalent to the coverage that the
8 beneficiary had immediately prior to disenrollment from the
9 program.

10 (b) Except as otherwise provided in this part, coverage provided
11 pursuant to this part shall be provided under the same terms and
12 conditions that apply to similarly situated subscribers in the
13 program under the applicable participating plan.

14 (c) (1) For a qualified beneficiary who was disenrolled from
15 the program prior to the operative date of this part, the participating
16 health, dental, or vision plan shall provide written notification of
17 eligibility for coverage pursuant to this section to the qualified
18 beneficiary within 30 days of the operative date of this part.

19 (2) For a qualified beneficiary who is disenrolled from the
20 program on or after the operative date of this part, the participating
21 health, dental, or vision plan shall provide written notification of
22 eligibility for coverage pursuant to this section to the qualified
23 beneficiary no less than 30 days prior to disenrollment from the
24 program.

25 (3) The notice required under this subdivision shall state that
26 the qualified beneficiary must elect the coverage in writing and
27 deliver the written request, by first-class mail, or other reliable
28 means of delivery, including personal delivery, express mail, or
29 private courier company, to the participating plan within 60 days
30 of the mailing of the notice. The notice shall also state that a
31 qualified beneficiary electing coverage pursuant to this part shall
32 pay to the participating plan the amount of the required premium
33 payment, as set forth in Section 12694.54.

34 (d) A qualified beneficiary shall have 60 days from the mailing
35 of the notice required under subdivision (c) to elect coverage
36 pursuant to this section. The election shall be in writing and shall
37 be delivered by first-class mail, or other reliable means of delivery,
38 including personal delivery, express mail, or private courier
39 company, to the participating plan.

1 (e) A qualified beneficiary receiving coverage pursuant to this
2 part shall continue to receive that coverage until the coverage is
3 terminated at his or her election or pursuant to Section 12694.56,
4 whichever occurs first.

5 (f) A qualified beneficiary receiving coverage pursuant to this
6 part shall be considered part of the participating plan and treated
7 as similarly situated subscribers for contract purposes, unless
8 otherwise specified in this part.

9 12694.54. (a) A qualified beneficiary who elects coverage
10 pursuant to this part shall make the following premium payments
11 to the participating health, dental, or vision plan, as applicable:

12 (1) To the participating health plan: not more than 110 percent
13 of the average per subscriber payment made by the board or the
14 department to all participating health plans for coverage provided
15 under the program to subscribers who are one year of age or older.

16 (2) To the participating dental plan: not more than 110 percent
17 of the average per subscriber payment made by the board or the
18 department to all participating dental plans for coverage provided
19 under the program to subscribers who are one year of age or older.

20 (3) To the participating vision plan: not more than 110 percent
21 of the average per subscriber payment made by the board or the
22 department to all participating vision plans for coverage provided
23 under the program to subscribers who are one year of age or older.

24 (b) The premium payments required by this section shall be
25 made before the due date of each payment but not more frequently
26 than on a monthly basis.

27 12694.56. The continuation coverage provided pursuant to this
28 part shall terminate at the first to occur of the following:

29 (a) The date 18 months after the effective date of coverage
30 elected pursuant to this part.

31 (b) The end of the period for which premium payments were
32 made, if the qualified beneficiary ceases to make payments or fails
33 to make timely payments of a required premium, in accordance
34 with Section 12694.54 and the terms and conditions of the policy
35 or contract. In the case of nonpayment of premiums, reinstatement
36 shall be governed by the terms and conditions of the policy or
37 contract.

38 (c) The qualified beneficiary moves out of the plan's service
39 area or the qualified beneficiary, or applicant acting on his or her
40 behalf, commits fraud or deception in the use of plan services.

1 SEC. 45. The Insurance Commissioner may adopt regulations
2 to implement the changes made to the Insurance Code by this act
3 pursuant to the Administrative Procedure Act (Chapter 3.5
4 (commencing with Section 11340) of Part 1 of Division 3 of Title
5 2 of the Government Code). The commissioner shall consult with
6 the Director of the Department of Managed Health Care prior to
7 adopting any regulations pursuant to this section for the specific
8 purpose of ensuring, to the extent practical, that there is consistency
9 of regulations applicable to entities regulated by the commissioner
10 and those regulated by the Director of the Department of Managed
11 Health Care.

12 SEC. 46. No reimbursement is required by this act pursuant
13 to Section 6 of Article XIII B of the California Constitution because
14 the only costs that may be incurred by a local agency or school
15 district will be incurred because this act creates a new crime or
16 infraction, eliminates a crime or infraction, or changes the penalty
17 for a crime or infraction, within the meaning of Section 17556 of
18 the Government Code, or changes the definition of a crime within
19 the meaning of Section 6 of Article XIII B of the California
20 Constitution.

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